Center for SUCCESSFUL AGING
HEALTH . VITALITY . WELL- BEING

CALIFORNIA STATE UNIVERSITY, FULLERTON

NeuroFit

MEDICAL CLEARANCE OF PERSONAL PHYSICIAN

Name of Patient _____

Your patient is interested in participating in the NeuroFit class, one of several physical activity programs offered by the Center for Successful Aging at California State University, Fullerton. The Center is under the direction of Koren Fisher, Ph.D., Associate Professor in the Department of Kinesiology.

Initial Assessment: All program participants are required to complete a health/activity questionnaire to identify any medical conditions, medications, or other physical conditions that will need to be accommodated for during the class. The assessments to be conducted are identified below. Please indicate whether you approve of your patient completing each of these assessments in the space provided.

Physical Parameters	Assessments	Approval
Cardiovascular	* 2-Minute Step in Place	yes ___ no ___
	* 6-Minute Walk	yes ___ no ___
Muscular Strength / Endurance	*30 Second Arm Curl	yes ___ no ___
	*30 Second Chair Stand	
Flexibility	* Chair Sit and Reach	yes ___ no ___
	* Back Scratch	yes ___ no ___
Balance & Gait	* 8-Foot Up and Go	yes ___ no ___
	* 50 ft. walking speed	yes ___ no ___

Exercise Program: The level of intensity of the program is based on the individual capabilities of each participant. The class meets twice per week for 75 minutes over a 12 week period. Each class will be instructed by trained personnel with extensive education and experience in exercise science and aging. The class will consist of a 10-minute warm-up, followed by circuit-based aerobic and resistance training exercises along with neuromotor fitness activities that focus on balance, agility, coordination and problem solving. The class concludes with a 5-minute cool-down.

Exercise Class Approval: yes ____ no _____

Please list any modifications/comments for testing and exercise class: _____

_____

Patient's last blood pressure reading: _____ / _____

Please indicate by your signature below that your patient is medically cleared to participate in the specific portions of testing and training as described. Please call Dr. Debra Rose if you have any question concerning the program at 657-278-2620.

_____ _____ _____

Print Name of Physician *Signature of Physician* ***Date***

Address: _____ *Physician phone #:* (____) _____ - _____

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