FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Parkinson's Programs Medical Clearance

Dear Dr. _____,

Your patient, _____Date of birth:_____ wishes to participate in a Parkinson's Program that we offer at our facility.

This program will consist of dynamic stretching, rhythmic walking, strength training, boxing and agility drills.

Patient must be able to:

- Be able to move from station to station
- Be able to get up and down from floor
- Be able to perform lateral movement, cardio movements and free weight exercises safely
- Be able to process form cues with minimal assistance

Patient may bring caregiver to assist with these things.

Patient may return this form to Michelle Urbanski, Health & Wellness Director, or physician may fax form to the YMCA of Greater Westfield, 413-572-3995. For questions/concerns, please contact Michelle Urbanski at (413)568-8631.

My patient,_____, may participate in the YMCA of Greater Westfield's Parkinson's program, **Fight PD.**

Recommendations or concerns: _____

_____

Physician's signature:_____ Date: _____

Physician's name and office address (please print):_____

_____

- I hereby give my physician permission to release any pertinent information and I understand that it will remain confidential.

Participant signature:_____

Date:_____