P.O.W.E.R. Program
Medical Clearance Form

Old Dominion University
Department of Recreation and Wellness
Norfolk, VA 23529
Phone: (757) 683-3384
Fax: (757) 683-3386

Dear Dr._____,

(Patient Name)_____ is interested in taking part in our P.O.W.E.R. Program (Participants Overcoming Obstacles with Exercise and Recreation). P.O.W.E.R. offers assistance to clients who need to be monitored while exercising. Upon a doctor's approval an Old Dominion University Doctor of Physical Therapy student conducts a pre-assessment which involves a basic evaluation of strength, flexibility, range of motion, cardiovascular and functional assessments. Based on the assessment, the clients' goals and a physician's clearance the instructor will provide the client with a comprehensive 12-week exercise program.

Below please check the special condition(s) and/or disease(s) your patient exhibits that require them to need assistance during exercise. If you know of any reason this person should not participate please indicate on the final page.

Thank you,

Melissa Turnage
Coordinator of Fitness & Wellness
Old Dominion University's Department of Recreation & Wellness

Conditions/Diseases currently affecting the patient's health
If denoted by * please explain severity of condition/disease in space provided.

√	**Cardiovascular Diseases**	Please Explain - Required if *
	Myocardial Infarction	
	Revascularization	
	Angina and Silent Ischemia	
	Atrial Fibrillation	
	Pacemakers and Implantable Cardioverter-Defibrillators	
	Valvular Heart Disease	
	Chronic Heart Failure	
	Cardiac Transplant	
	Hypertension	
	Peripheral Arterial Disease	
	Aneurysms	

√	**Pulmonary Diseases**	Please Explain - Required if *
	Chronic Obstructive Pulmonary Disease (COPD)	
	Chronic Restrictive Pulmonary Disease	
	Chronic Asthma	
	Cystic Fibrosis	
	Lung and Heart-Lung Transplantation	
√	**Metabolic Diseases**	Please Explain - Required if *
	Hyperlipidemia	
	End-Stage Metabolic Disease	
	Diabetes	
	Obesity *	
	Frailty	
√	**Immunological and Hematological Disorders**	Please Explain - Required if *
	Cancer	
	Acquired Immune Deficiency Syndrome (AIDS)	
	Abdominal Organ Transplant	
	Chronic Fatigue Syndrome	
	Fibromyalgia	
	Bleeding and Clotting Disorders	
√	**Orthopedic Disease and Disabilities**	Please Explain - Required if *
	Arthritis *	
	Lower Back Pain Syndrome *	
	Osteoporosis	
	Lower-Limb Amputation	
	Post rehabilitation *	
	Quadriplegia & Paraplegia	

√	**Neuromuscular Disorders**	Please Explain - Required if *
	Stroke and Brain Injury	
	Spinal Cord Disabilities	
	Muscular Dystrophy	
	Epilepsy	
	Multiple Sclerosis	
	Polio and Post-Polio Syndrome	
	Amyotrophic Lateral Sclerosis	
	Cerebral Palsy	
	Parkinson's Disease	
√	**Cognitive, Psychological, and Sensory Disorders**	Please Explain - Required if *
	Intellectual Disabilities *	
	Alzheimer's Disease	
	Mental Illness	
	Stress and Anxiety Disorders *	
	Deaf and Hard of Hearing *	

√		Please Explain
	I know of no reason why the applicant may not participate in the POWER Program.	
	I believe the applicant may participate but I urge caution because:	
	The applicant may not participate in the following activities:	
	I recommend the applicant NOT participate in the POWER Program	
	Visual Impairment *	

Severity of condition(s)/disease(s) denoted by *:

_____

_____

_____ I know of no reason why the applicant may not participate

_____ I believe the applicant can participate but I urge caution because:

_____

_____

_____ The applicant should not engage in the following activities:

_____

_____

_____ I recommend the applicant not participate.

Signature of Doctor _____

Date _____ Phone Number _____

Client Contact Information:

Name _____

Phone Number _____

Email Address _____

General Times Available:

Monday: _____ Saturday: _____

Tuesday: _____ Sunday: _____

Wednesday: _____

Thursday: _____

Friday: _____