**Greetings Potential Fit For Life Participant**

Thank you for your interest in joining the Fit For Life program at the Activities and Recreation Center (ARC) and making a step to improve your overall health and well-being. As individuals mature into later stages in life, it is important to remain active, not only physically, but mentally and socially as well. The Fit for Life Program offers many outlets to physical and social gatherings in hopes of keeping the UC-Davis community active and engaged.

Please take a couple of minutes to complete the following paperwork which is required to enroll in the program.

* PART I: Personal Information
* PART II: Medical and Health History
* PART III: Health Related Behavioral Assessment
* PART IV: Physical Activity Readiness Questionnaire (PAR-Q)
* PART V: Waiver of Liability, Assumption of Risks and Indemnification Agreement
* Physician Clearance Form

## When all documents have been completed (including the medical clearance form), please contact Lisa Cachia via e-mail at lcachia@ucdavis.edu to schedule a consultation appointment. Please be sure to bring your completed paperwork with you to this appointment.

The Living Well Unit is excited to provide a program such as Fit For Life to the UC-Davis community and hope you will enjoy being a member of this invaluable program. If you have any further questions, comments or concerns, please visit the Fit for Life page at campusrecreation.ucdavis.edu or contact Lisa Cachia.

Thank you for your interest and I look forward to meeting you.

Sincerely,

Lisa Cachia

Lisa Cachia

Coordinator, Living Well

University of California-Davis

Department of Campus Recreation

Email: lcachia@ucdavis.edu

Phone: 530-754-0127

http://campusrecreation.ucdavis.edu

**PART I: PERSONAL INFORMATION**

Legal Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Phone number of personal physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Phone number of emergency contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Status (e.g. retiree, alumni, faculty/staff) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: *Male* or *Female*  Age\_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_ Weight: (now \_\_\_\_\_\_\_\_\_\_lbs.; One year ago\_\_\_\_\_\_\_\_\_\_\_\_\_ lbs.

\*\*Please indicate times that you ARE available for a 15-30 minute consultation\*\*

 *Days Times*

 Monday ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Tuesday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Wednesday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Thursday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Friday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Weekends \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List three goals that you want to achieve

(Ex: improve physical health, become more active, learn more about successful aging, maintain physical health, become a part of an active community etc)

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about the Fit for Life Program?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What do you hope to gain or learn from the Fit for Life program?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PART II: MEDICAL & HEALTH HISTORY**

**Complete each question accurately and to the best of your knowledge. All information provided is confidential.**

1. Circle (if applicable) any immediate male family members succumbed to a heart attack before age 55:

 *father brother son*

*2.* Circle (if applicable) any immediate female family members that succumbed to a heart attack before age 65:

 *mother sister daughter*

1. Date of last medical, physical exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last physical fitness test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Circle any body parts below that have underwent any medical or surgical procedure(s) in the last 10 years:

*Back Heart Kidney Eyes Knee Neck*

*Ears Hernia Lung Elbow Shoulder Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*6.* Please circle any of the following for which you have been diagnosed or treated by a physician or health professional:

*alcoholism diabetes mental illness*

*anemia, sickle cell emphysema neck strain*

*anemia, other epilepsy obesity*

*asthma eye problems osteoporosis*

*back strain gout phlebitis*

*bleeding trait hearing loss rheumatoid arthritis*

*bronchitis, chronic heart problem stroke*

*cancer high blood pressure thyroid problem*

*cirrhosis, liver hypoglycemia kidney problem*

*concussion hyperlipidemia ulcer*

*congenital defect joint problems other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *7.* Circle all medicine taken in the last 6 months:

*blood thinner epilepsy medication nitroglycerin insulin*

 *diabetic heart rhythm medication high blood pressure medication*

 *digitalis diuretic other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

1. Circle the number indicating how often you have each of the following:

 1= very often, 2 = fairly often, 3= sometimes, 4= infrequently, 5= never

1. *Cough up blood 1 2 3 4 5*
2. *Dizziness 1 2 3 4 5*
3. *Arm or Shoulder pain 1 2 3 4 5*
4. *Abdominal Pain 1 2 3 4 5*
5. *Breathlessness 1 2 3 4 5*
6. *Fatigue with minimal exertion 1 2 3 4 5*
7. *Low Back Pain 1 2 3 4 5*
8. *Swollen Joint 1 2 3 4 5*
9. *Leg Pain/Numbness 1 2 3 4 5*
10. *Tremors 1 2 3 4 5*
11. *Abnormal fatigue with normal activity 1 2 3 4 5*

**PART III: HEALTH-REALTED BEHAVIORAL ASSESSMENT**

**Complete each question accurately and to the best of your knowledge. All information provided is confidential.**

 Number of hours worked per week: *Less than 20 20-40 41-60 over 60*

 You are able to deal with stress well (circle one):

 *Strongly agree moderately agree neutral moderately disagree disagree*

 You feel your energy level is adequate (circle one):

 *Strongly agree moderately agree neutral moderately disagree disagree*

 You are a time conscious individual (circle one):

 *Strongly agree moderately agree neutral moderately disagree disagree*

 You spend more than 25% of your job: (circle all that apply)

 *sitting at your desk lifting or carrying loads standing walking driving*

 Do you currently take any nutritional supplements or follow any special diet(s)? (e.g. vegetarian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you smoke (or have quite smoking in the past 6 months*)? yes no*

 If you are a smoker, circle the smoking method and frequency per day:

 *Cigarettes: 40 or more 20-39 10-19 1-9*

 *Cigars or pipes only: 5 or more less than 5*

 Do you exercise regularly (i.e. accumulate at least 30 min per day)? *yes no*

 How many days per week do you accumulate 30 min. of moderate activity?

 (Moderate activity can be defined **as** working hard at about a level-six intensity on a scale of 10. You should still be able to carry on a conversation during exercise).

 *0 1 2 3 4 5 6 7 8 9 10*

 How many days per week do you normally spend at least 20 min. of vigorous exercise?

 (Vigorous exercise is can be characterized as breathing rapidly and only able to speak in short phrases. Your heart rate is substantially increased and you are likely to be sweating).

 *0 1 2 3 4 5 6 7 8 9 10*

 Please list any current activities you participate in and/or enjoy.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Please list activities that are physically challenging for you or that you dislike. Explain,

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Do you feel you are able to walk 1 mile at a brisk pace (12-14 minutes/mile) with limited fatigue?  *yes no unsure*

**PART IV: PHYSICAL ACTIVITY READINESS QUESTIONAIRE (PAR-Q)**

Regular physical activity is essential for successful aging and overall mental and physical well-being. Mature individuals are now seeking out physical activity and becoming increasingly more active every day. Being active is safe for most individuals, however, as the body begins to mature and reach the later stages in life it is important to gain insight into proper activity as prescribed by a physician.

Before joining the Fit for Life Program, all individuals must complete the PAR-Q, and if applicable, action must be taken to visit your physician before attending a class. This is for your safety and will inform us of modifications or options that should be made to accommodate the individuals in the program.

**Please read the questions carefully and answer each one honestly with a check of YES or NO.**

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** |  |
|  |  | 1.       Are you a male over the age of 45 or a female over the age of 55? |
|  |  | 2.       Has your doctor ever said that you have a heart condition and that you  should only do physical activity recommended by a doctor? |
|  |  | 3.       Do you feel pain in your chest when you do physical activity? |
|  |  | 4.       In the past month, have you had chest pain when you were not doing a  physical activity?  |
|  |  | 5.       Do you lose your balance because of dizziness or do you ever lose  consciousness? |
|  |  | 6.       Do you have a bone or joint problem that could be made worse by a  change in your physical activity?  |
|  |  | 7.       Is your doctor currently prescribing drugs (e.g. water pills) for your blood  pressure or heart condition?  |
|  |  | 8.       Do you know of any other reason why you shouldn’t do physical activity? |

|  |
| --- |
| **If you answered YES to one or more questions** |
| 1. Discuss with your physician the PAR-Q and which question(s) you answered yes.
2. Have the physician complete the Physician Clearance form (attached) indicating any special precautions or modifications that should be considered.
3. Return the Physician Clearance form to the Fitness and Wellness Center upon completion by the physician.
 |
| **If you answered NO to all questions** |
| It can be assumed that you are able to:* Engage in physical activity- beginning slowly and gradually increasing intensity.
 |

**Postpone activity if:**

\*You are not feeling well because of temporary illness such as cold or fever.

**PLEASE NOTE: If your health status changes resulting in a change to any of your answers to the above questions, or you intend to have a medical procedure in the near future, notify Brian Luu and consult your physician immediately for possible modifications to your activity.**

**I have read, understood the Physical Activity Questionnaire honestly and to the best of my knowledge.**

**Name (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PART V: WAIVER OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION AGREEMENT**

Participant's name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Print

UNIVERSITY OF CALIFORNIA, DAVIS

Campus Recreation Programs & Services

**Waiver of Liability, Assumption of Risk, and Indemnity Agreement**

**Waiver**: In consideration of being permitted to participate in any way in Campus Recreation and Programs & Services hereinafter called "The Activity", I, for myself, my heirs, personal representatives or assigns, **do hereby** **release, waive, discharge, and covenant not to sue** The Regents of the University of California, its officers, employees, and agents from liability **from any and all claims including the negligence of** **The Regents of the University of California, its officers, employees and agents,** resulting in personal injury, accidents or illnesses (including death), and property loss arising from, but not limited to, participation in The Activity.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian of Minor Date Signature of Participant Date

**Assumption of Risks:** Participation in The Activity carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. The specific risks vary from one activity to another, but the risks range from 1) minor injuries such as scratches, bruises, and sprains 2) major injuries such as eye injury or loss of sight, joint or back injuries, heart attacks, and concussions to 3) catastrophic injuries including paralysis and death.

**I have read the previous paragraphs and I know, understand, and appreciate these and** **other risks that are inherent** in The Activity. I hereby **assert that my participation is voluntary and** **that I knowingly assume all such risks.**

**Indemnification and Hold Harmless:** I also agree to INDEMNIFY AND HOLD The Regents of the University of California HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney’s fees brought as a result of my involvement in The Activity and to reimburse them for any such expenses incurred. The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is intended to be as broad and inclusive as is permitted by the law of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

**Acknowledgment of Understanding:** I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, and **understand that I am giving up substantial** **rights, including my right to sue**. I acknowledge that I am signing the agreement freely and voluntarily, and **intend by my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature of Participant Date

**PHYSICIAN CLEARANCE FORM**

Dear Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ would like to begin the Fit for Life program with the Activities and Recreation Center (ARC), Department of Campus Recreation, University of California Davis. After reviewing his/her response to our health-screening questionnaire (PAR-Q), we would appreciate your medical opinion and recommendations concerning his/her participation in physical activity. Please provide the following information and return this form to the patient.

The activities/classes will involve the following:

* Aerobic exercise
	+ Intensity – mild to moderate (60%-90% VO2 max)
	+ Frequency – 2-4 times per week
	+ Duration – 20-40 minutes per session
	+ Modes – walking, jogging, swimming, stepping, cycling, aerobic dance, et al.
* Anaerobic exercise
	+ Intensity – moderate to high (70%-80%, 1 rep max); 6-12 repetitions per set
	+ Frequency – 2-3 times per week
	+ Duration – 30-60 minutes per session
	+ Modes – resistance machines & free weight
* Flexibility exercises – 20-40 seconds of static stretching to increase ROM about joints

If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers, or has no effect):

 Type of medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Effect \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Physician signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone/Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for your assistance.

 For more information about the ARC Living Well Program, please contact Lisa Cachia, Living Well Coordinator at lcachia@ucdavis.edu or 530-754-0127

(Please fax to 530-754-8444)