

REQUEST FOR PARTICIPATION IN THE PHYSICAL EXERCISE PROGRAM

TO: Evaluating Physician

EMPLOYEE NAME:

PHONE:

EMPLOYER / MAIL CODE:

The NASA Exchange exercise facility staff are trained in the use of all the facility's equipment which is similar to that found in commercial health and fitness clubs. They can instruct exercise participants in the use of the equipment and monitor the facility to ensure the proper use of the exercise equipment. There are no special types of medical monitoring available in the facility (e.g., heart rate monitors), nor will any type of medical monitoring be done. Exercisers are taught to monitor their pulse rate, to exercise within an age-specified training heart rate zone, and to note their subjective feelings upon exertion. Any special medical precautions are the responsibility of the exerciser and his/her physician. If an exercise prescription is written by a participant's physician, the exercise facility personnel will help train the individual in the use of the appropriate equipment if available.

If you have questions concerning the exercise facility staff, equipment, or any special concerns for the participant, please call the Exchange (544-3337 or 544-7564).

PRECAUTIONS / LIMITATIONS:

MEDICATIONS:

The above named individual is medically cleared to use the MSFC/NASA Exchange exercise facility.

TYPE OR PRINT PHYSICIAN'S NAME:

NASA

PERSONAL

PHYSICIAN'S SIGNATURE:

DATE:

NOTE: This clearance is good for three (3) years from the above date. In the interim, if there are any changes in your medical status, the exerciser and his/her physician should advise the exercise facility staff.

DATE:	BLOOD PRESSURE:
HEIGHT:	WEIGHT (LBS):

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

EMPLOYEE NAME (LAST, FIRST, MI):	PHONE:
LAST SIX (6) DIGITS OF YOUR SOCIAL SECURITY NO.:	DATE OF BIRTH:

IS THIS YOUR FIRST TIME USING THE EXERCISE FACILITY?

YES NO

EMAIL ADDRESS:

EMERGENCY CONTACT:	RELATION:
PHONE:	<input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> PARENT <input type="checkbox"/> OTHER _____

QUESTION	YES	NO
Has a doctor ever said that you have a heart condition and recommended only medically-supervised activity?		
Do you have chest pain brought on by physical activity?		
Have you developed chest pain in the past month?		
Have you on one or more occasions lost consciousness or fallen over as a result of dizziness?		
Do you have a bone or joint problem that could be aggravated by the proposed physical activity?		
Has a doctor ever recommended medication for your blood pressure or a heart condition?		
Are you aware, through your own experience or a doctor's advice, of any other physical reason that would prohibit you from exercising without medical supervision?		

IF "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE EXPLAIN:

By my signature below, I acknowledge my responsibility to maintain current medical clearance, to advise the exercise staff of changes in my medical profile, and to abide by all rules and policies in place while using this facility.

EMPLOYEE'S SIGNATURE:	DATE:
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