



Senior Citizens Division

(228) 769-8329

Physical Activity Clearance Form
Fitness Room - Pascagoula Senior Center

Clearance requested for: (Your Name) _____ DOB _____

Health care provider's name: (Doctor's Name) _____

Please sign the statement that reflects your wishes:

- 1. ___ This patient may engage in an exercise program only under clinical supervision.
2. ___ This patient may engage in an exercise program only under the supervision of a community-based health club professional.
3. ___ This patient may engage in independent (unrestricted) moderate intensity exercise at the Pascagoula Senior Center. This program is unsupervised, but participants will be instructed on the proper use of the equipment by an exercise physiologist.

- ___ Airdyne ___ Arm Ergometer
___ Treadmill ___ Recumbent Cycle
___ NuStep ___ Cross Trainer Elliptical
___ Hand Weights

*Health care provider's signature: _____ Date: _____ *Doctor Signs

**Exercise Physiologist signature: _____ Date: _____ **SRHCR or HealthPlex Representative Signs

Return form to: PASCAGOULA SENIOR CENTER
P.O. Drawer 908, 1912 Live Oak Ave.
Pascagoula, MS 38568

This form is valid for 12 months from date of completion. This clearance is no longer valid if there is a change in health condition.

AHA/ACSM Pre-Participation Screening Questionnaire

Assess your health status by marking all true statements:

HISTORY

You have had:

- A heart attack
- Heart surgery
- Cardiac catheterization coronary
- Angioplasty (PTCA)
- Pacemaker/implantable cardiac defibrillator
- Rhythm disturbance
- Heart valve disease
- Heart failure
- Heart transplantation
- Congenital heart disease

SYMPTOMS

- You experience chest discomfort with exertion
- You experience unreasonable breathlessness
- You experience dizziness, fainting or blackouts
- You take heart medications

OTHER HEALTH ISSUES

- You have diabetes
- You have asthma or other lung disease
- You have burning or cramping sensation in your lower legs when walking short distances
- You have musculoskeletal problems that limit your physical activity
- You have concerns about safety of exercise

IF YOU MARKED ANY OF THESE STATEMENTS IN THIS SECTION, CONSULT YOUR PHYSICIAN OR OTHER APPROPRIATE HEALTHCARE PROVIDER BEFORE ENGAGING IN EXERCISE.

CARDIOVASCULAR RISK FACTORS

- You are a man over 45 years
- You are a woman over 55 years, have had a hysterectomy or are postmenopausal
- You smoke, or quit smoking within the previous 6 months
- Your blood pressure is greater than 140/90mm Hg
- You do not know your blood pressure
- You take blood pressure medication
- Your blood cholesterol level is greater than 200mg/dl
- You do not know your cholesterol level
- You have a close blood relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)
- You are physically inactive (i.e. you get less than 30 minutes of physical activity on at least 3 days/week)
- You are 20+ pounds overweight

IF YOU MARKED TWO OR MORE OF THESE STATEMENTS IN THIS SECTION, CONSULT YOUR PHYSICIAN OR OTHER APPROPRIATE HEALTHCARE PROVIDER BEFORE ENGAGING IN EXERCISE.

- None of the above are true

YOU SHOULD BE ABLE TO SAFELY EXERCISE WITHOUT CONSULTING YOUR PHYSICIAN OR OTHER APPROPRIATE HEALTHCARE PROVIDER IN ALMOST ANY FACILITY THAT MEETS YOUR EXERCISE PROGRAM NEEDS.