

ATRF_Wellness_Center_Pre-Activity_Fitness_Profile

Information supplied is strictly confidential

FOLLOW THESE STEPS TO COMPLETE THIS FORM:

1. Complete this form and return it to:
ATRF Occupational Health Services
8560 Progress Drive
Room: E1006-1008
Frederick, MD 21701
Phone: 301-228-4922
Fax: 301-846-6150
Or interdepartmental mail to OHS Building 426
2. Regular physical activity is relatively safe for most people. However, some individuals who may be at risk for underlying health conditions should check with their personal health care provider before starting an exercise program. The Pre-activity fitness profile will help us identify possible risk factors that may affect your ability to exercise safely. Keep in mind that the presence of risk factors may not preclude you from beginning an exercise program, but it will assist us in addressing any medical concerns that may cause modifications to your exercise program.
3. Please make sure your form is complete before submitting it to OHS. After we review your form, and if no further evaluation is necessary, you can start exercising. Please, call us at 301-846-1096 if you have any questions.
4. This form is not a substitute for a thorough physical examination, assessment and diagnosis by your physician. It is designed to identify adults for whom physical activity might be inappropriate at this time. OHS strongly recommends that each client undergoes a medical examination by your physician before beginning any exercise programs.



Health history questionnaire – part II

! If you answer YES to (2) two or more questions below you will need to take the last page of this form to your physician and obtain a signed medical clearance before enrolling in the health club.

- Yes No 1. Are you currently being treated for a bone or joint problem, such as arthritis, or tendonitis, that restricts your ability to exercise? Explain _____

- Yes No 2. Do you have high blood pressure as reported by a physician (greater than 140/90 mm/hg) are you on blood pressure medication?
- Yes No 3. Do you have high cholesterol as reported by your physician (greater than 200mg/dl or are you on cholesterol medication?
- Yes No 4. Do you smoke?
- Yes No 5. Are you currently exercising LESS than one hour per week?
- Yes No 6. Do you have accumulation of fat around the waist as indicated by your Physician?
- Yes No 7. Are you a male over 45 years of age or female over 55 years of age? (Circle)

Informed consent and release

I declare that I intend to use some or all of the activities, facilities, programs, and services offered by FNLCR at the ATRF Wellness Center and I understand that each person, (myself included), has a different capacity for participating in such activities, facilities, programs & services. I am aware that all activities, services, and programs offered are educational, recreational, or self-directed in nature. I assume full responsibility, during and after my participation, for my choices to use or apply, at my own risk, any portion of the information or instruction I receive. I understand that part of the risk involved in undertaking any activity or program is relative to my own state of fitness or health (physical, mental, or emotional) and to the awareness, care and skill with which I conduct myself in that activity or program. I acknowledge that my choice to participate in any activity, service, and programs of FNLCR at the ATRF brings with it my assumption of those risks or results stemming from this choice and the fitness, health, care and skill that I possess and use.

I recognize that by participating in the activities, facilities, programs and services offered by FNLCR at the ARTF Wellness Center I may experience potential risks such as transient light-headedness, fainting, abnormal blood pressure, chest discomfort, leg cramps, and nausea and that I assume will fully those discomfort, fatigue, or any other symptoms that I may suffer during and immediately after my participation. I understand that I may stop or delay my participation in any activity or procedure and seek medical evaluation.

In the event that I am injured and unable to provide verbal consent, I do hereby consent to first aid, emergency medical care and if necessary, transportation to an accredited hospital or an emergency center when necessary for executing such care, for treatment of injuries that I may sustain while participating in any activities at the ATRF Wellness Center.

I recognize that exercise is not without some risk to the musculoskeletal system (sprains, strains) and cardio respiratory system (dizziness, fainting, abnormal heartbeat, discomfort in breathing, abnormal blood pressure, in rare instances heart attack or stroke) I hereby certify that I know of no medical problem (except those on the fitness profile questionnaire) that would increase my risk of illness or injury as a result of participation in a regular exercise program. I understand that the completion of this form will not result in any type of diagnosis of disease and that it is not intended as a substitute for consultation with my personal health care provider. I must consult my own personal health care provider for any evaluation of my health status. I hereby waive, discharge, absolve, hold harmless and forever release FNLCR and ATRF Wellness Center its employees, officers, agents, representatives, executors, and all those associated with FNLCR (including Leidos Biomedical Research, Inc. and NCI-Frederick) from any and all liability arising out of any accident, injury, or loss sustained by me as a result of activities at or present in FNLCR-ATRF Wellness Center, activities, programs and services. The terms of this release and waiver shall apply to my heirs, estate, executor, administrator, assignees and all members of my family.

Emp I.D. or PIV #: _____

PRINT NAME _____

SIGNATURE _____ DATE _____

PROFILE REVIEWED BY _____ DATE _____

To be completed by personal health care provider

If you require a medical release please have your health care provider complete this part. For quicker response you can fax this page to your health care provider.

_____, has applied to participate in the Frederick National Lab (FNLCR) ATRF Wellness Center and hereby authorizes the health care provider identified below ("You") to disclose the information identified below (collectively, the "Authorized Information") to Leidos Biomedical Research, Inc. OHS ATRF Clinic at the address first set forth above for the purpose of evaluating any limitations on the patient's participation under.

Patient Acknowledgement and Authorization

I understand that the entity receiving the authorized information is an occupational health care clinic covered by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying in writing the person(s) I identified above as authorized to use or disclosed authorized information; however, I understand that any such revocation will not affect any actions taken before the revocation has been received.

I understand that I may refuse to sign this authorization and that you may not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on whether or not I sign this authorization.

SIGNATURE _____

DATE _____

This Authorization is valid for 12 months after the date signed indicated above.

Authorized Information: Provider please complete below:

Within past 12 months)

Blood Pressure _____ mm/Hg, Pulse Rate _____ bpm, Cholesterol _____ mg/dl,

HDL _____ mg/dl

Please comment on abnormal conditions (respiratory or circulatory) identified in the Health History above and include any relevant medical history.

Medical Clearance (check one): To my knowledge and based upon a current review of the above named patient I, the undersigned recommend:

No Physical Activity. Clearance denied at this time

Progressive Physical Activity: (Please discuss with patient)
with the avoidance of:

 Unrestricted Physical Activity. No contraindicating for his/her participation in an exercise program

Name, Address & Telephone Number of Health Care Provider

Signature of Health Care Provider:

Date:

Please return to:

ATRF OHS Clinic

8560 Progress Drive

Frederick, Md. 21701

Fax: 301-846-6150

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