

Dear Physician:

_____ has inquired about becoming involved in our Adult Fitness Program. This program involves participating in activities designed to improve cardiovascular fitness. Each participant is provided with an individually prescribed exercise program. The prescribed program is based upon the results of the following testing:

- I. Work capacity test on a treadmill using the Balke protocol. This is a progressively graded exercise test which continues until a heart rate of 85% of maximum is achieved. Heart rate, blood pressure, ECG and perceived exertion are monitored before, during and following the test.
- II. Body Composition and Ideal Weight Determination
 - A. Hydrostatic weighing (with Residual Volume)
 - B. Skinfold measurement
 - C. Ideal weight determination and weight control program if indicated
 - D. Computer assisted nutrition evaluation
- III. Pulmonary Function Testing
 - A. Vital capacity
 - B. FEV_{1.0}
 - C. FEV 1.0
FVC
 - D. Residual volume
- IV. Flexibility Testing and Stretching Routine

Before entering our program, each participant is required to obtain clearance from his/her personal physician. Because the American College of Sports Medicine recommends that individuals 35 years and older have a complete physical before an exercise program, we would ask that this procedure be followed. In addition to your signature, it would be appreciated if the following information (if available) would be forwarded to our laboratory.

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1. Drugs the patient is taking that may affect the exercise test.

2. Resting 12-lead electrocardiogram _____

3. Blood Pressure _____

4. Blood Profile Date _____

a. Total cholesterol _____

b. LDL cholesterol _____

c. HDL cholesterol _____

d. Triglycerides _____

e. Glucose _____

5. Additional information that will help us to be more effective in assisting your patient:

Should you have any questions, please notify me. Thank you for your cooperation.

Sincerely,

Dr. David W. Bacharach
Professor/Director

I have examined _____ and found him/her to be physically capable to participate in the described exercise program.

Physician's Signature

Physician's Printed Name & Clinic

Date _____

Phone _____

Please return completed form to:

Dr. David W. Bacharach
St. Cloud State University
Halenbeck Hall 111
720 Fourth Ave. S.
St. Cloud, MN 56301-4498
Fax: 320-308-5399