# LIVESTRONG® AT THE YMCA PROGRAM ENROLLMENT FORM

## PARTICIPANT DETAILS

*required information

*Registration Date: _____ /_____ /_______

| *First Name: | Nickname/preferred: | *Last Name: |
|---|---|---|

| *Date of Birth: _____ /_____ /_______ (MM DD YYYY) | *Sex: ☐ Male ☐ Female | Address Street 1:<br>Street 2:<br>City:<br>*State: *ZIP Code: |
|---|---|---|
| Home Phone: ( ) - | *Mobile Phone: ( ) - | |
| Email: | | Preferred Contact Method (*select one*):<br>☐ Email ☐ Mobile - Call<br>☐ Home Phone ☐ Mobile - Text |

| How did you hear about the program? | *What is your highest level of education? | *What is your race? (Check all that apply) |
|---|---|---|
| ☐ Current/Former Program Participant<br>☐ Doctor/Other Health Care Professional<br>☐ Employer<br>☐ Family/Fried/Word of Mouth<br>☐ Health Insurance Company<br>☐ Media/Marketing<br>☐ Screening Event/Health Fair<br>☐ Y Staff Member/Volunteer<br>☐ Other | ☐ Less than high school<br>☐ High school diploma or GED<br>☐ Associate degree<br>☐ Bachelor's degree<br>☐ Master's degree<br>☐ Doctorate<br>☐ Professional degree (MD, JD, DDS, etc.)<br>☐ Other | ☐ American Indian/Alaska Native<br>☐ Asian<br>☐ Black or African American<br>☐ Native Hawaiian or Other Pacific Islander<br>☐ White or Caucasian<br>☐ A race not listed here<br>☐ Prefer not to answer |
| *Are you of Hispanic, Latino(a), or Spanish Origin?<br>☐ Yes<br>☐ No<br>☐ Prefer not to answer | Are you a member of the Y?<br>☐ Yes<br>☐ No | Employer Name:<br>______________________________ |

*YMCA Staff Use ONLY:*

| Participant Status: ☐ Enrolled ☐ Wait list | Class/Cohort Name: | Class Location: |
|---|---|---|
| Instructor:<br>1.<br>2. | Below forms are signed and on file:<br>☐ Medical Clearance Form<br>☐ Consent and Release from Liability<br>☐ Authorization for Use and Disclosure of Health Information<br>☐ Authorization for Release of Information to Health Care Provider | |

Updated 10/2019

Copyright © 2019 by YMCA of the USA. All rights reserved.

## HEALTH INFORMATION

| **Where were you treated?** |
| --- |
| **Physician name:** |

**Have you ever had any of the following health conditions?**

| Condition | |
| --- | --- |
| Pulmonary (lung) problems | ☐ Yes |
| Heart problems or surgery | ☐ Yes |
| Diabetes | ☐ Yes |
| Altered heart rate | ☐ Yes |
| Dizziness or fainting (unrelated to cancer treatment) | ☐ Yes |
| Chest, neck or arm pain | ☐ Yes |
| Pain or cramping in legs while walking | ☐ Yes |
| Short-term weakness on one side of the body | ☐ Yes |
| Elevated blood pressure | ☐ Yes |
| Low blood pressure | ☐ Yes |
| High cholesterol | ☐ Yes |
| Smoker or previous smoker | ☐ Yes |
| Arthritis | ☐ Yes |
| Other (please specify): | ☐ Yes |

**If you answered 'YES' to any of the above, please describe briefly:**

*Type of Cancer:**

| | | | | |
| --- | --- | --- | --- | --- |
| ☐ Bladder | ☐ Endometrial | ☐ Lung | ☐ Prostate | ☐ Thyroid |
| ☐ Bone | ☐ Esophageal | ☐ Lymphoma | ☐ Rectal | ☐ Uterine |
| ☐ Brain | ☐ Head and Neck | ☐ Myeloma | ☐ Melanoma | ☐ Other (please specify): |
| ☐ Breast | ☐ Kidney (Renal Cell) | ☐ Oral | ☐ Skin (Non Melanoma) | |
| ☐ Cervical | ☐ Leukemia | ☐ Ovarian | ☐ Stomach (Gastric) | |
| ☐ Colon and Rectal | ☐ Liver | ☐ Pancreatic | ☐ Testicular | |

| **Cancer Diagnosis Date (MM/YYYY):** | | | |
| --- | --- | --- | --- |
| **Surgery?** | ☐ Yes | ☐ No | If yes, date of most recent surgery (MM/YYYY): |
| **Chemotherapy?** | ☐ Yes | ☐ No | If yes, date of last treatment (MM/YYYY): |
| **Radiation?** | ☐ Yes | ☐ No | If yes, date of last treatment (MM/YYYY): |

Updated 10/2019
Copyright © 2019 by YMCA of the USA. All rights reserved.

**Do you have an implemented port or Central Venous Access Catheter**? ☐ Yes ☐ No

If yes, specify location:

**Are you experiencing peripheral neuropathy (i.e. tingling/loss of sensation in your fingers and/or toes)?** ☐ Yes ☐ No

If yes, specify location:

**Has the cancer spread to any bones?** ☐ Yes ☐ No

If yes, please describe where:

**Have you had any lymph nodes removed?** ☐ Yes ☐ No

If YES:

**Where have you had lymph node involvement?**

☐ Head and Neck

☐ Left Upper Extremity

☐ Left Lower Extremity

☐ Right Upper Extremity

☐ Right Lower Extremity

**Check all that are true:**

☐ I have been DIAGNOSED with Lymphedema.

☐ I am currently experiencing STIFFNESS or LOSS OF RANGE OF MOTION in the area that the lymph nodes have been removed.

☐ I am currently experiencing PAIN or DISCOMFORT in the area that the lymph nodes have been removed.

**Are there any other major illnesses, injury or issues (physical or psychological) we should be aware of?** ☐ Yes ☐ No

If yes, please explain:

**List current medications, including vitamins and over the counter** (If not applicable, record 0)

**Describe your health at the present time:** ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor


Copyright © 2019 by YMCA of the USA. All rights reserved.

## PHYSICAL ACTIVITY INFORMATION

**Do you participate in exercise regularly?** ☐ Yes ☐ No

If YES:

**Please describe the FREQUENCY of your exercise:**
☐ Daily
☐ 2-6 times a week
☐ Once a week
☐ Less than once per week
☐ Monthly

**Please describe the INTENSITY of your exercise:**
☐ Light
☐ Moderate
☐ Vigorous

**Please list the TYPES of exercise you participate in regularly:**

**Do you have any physical limitations that restrict your daily living activities or ability to exercise?** ☐ Yes ☐ No

If yes, please explain:

**Are there any other limitations since your cancer diagnosis?** ☐ Yes ☐ No

If yes, please explain:

**Are you working?**

If YES:

**What is your level of activity at work:**
☐ Sedentary
☐ Light
☐ Moderate
☐ Vigorous

If NO:

**Since when:** _____________ (insert date)

**Describe your past experience with resistance training and aerobic training:**

**What expectations do you have from this program?**

**Do you have any concerns about starting this exercise program?**


Copyright © 2019 by YMCA of the USA. All rights reserved.

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

| Participant Name: | | |
|---|---|---|
| Date of Birth (MM/DD/YYYY): | Phone Number: | |
| Mailing Address: | | |
| City: | State: | Zip Code: |
| Email Address: | | |
| Emergency Contact Name: | | |
| Relationship to Participant: | Emergency Contact Phone Number: | |

## LIVE**STRONG**® at the YMCA CONSENT AND RELEASE FROM LIABILITY

I hereby consent to voluntarily participate in LIVE**STRONG** at the YMCA with the Eastern Carolina YMCA, Twin Rivers YMCA. I understand the goal of the program is to help adult cancer survivors develop and maintain cardiorespiratory fitness, muscular strength and endurance, flexibility and balance. The program is designed to gradually increase workload on the body to improve overall fitness. The rate of progression is regulated by the rate of my perceived effort of activity. I understand I am responsible for monitoring my own condition throughout the program and should any symptoms occur, I would cease my participation and inform the Instructor and my physician of the symptoms.

I agree to consult my physician and obtain written permission from my physician prior to the commencement of the LIVE**STRONG** at the YMCA Program. I understand the YMCA does not practice medicine and LIVE**STRONG** at the YMCA is not a substitute for the care I receive from my physician or other qualified health care providers. I understand the LIVE**STRONG** Instructor is not a qualified health care professional, does not practice medicine, and support provided by the Instructor is not a substitute for the care I receive from my qualified health care providers.

In consideration for being allowed to participate in this program, I agree to assume the risk of such physical activity, and further agree to hold harmless the YMCA, its employees and agents, from any and all claims, suits, losses or related causes of action for damages, including, but not limited to, such claims that may result in my injury or death, accidental or otherwise, during or arising in any way from my participation in the LIVE**STRONG** at the YMCA Program.

By signing below, I affirm that I have read the above in its entirety, and I understand the nature of the LIVE**STRONG** at the YMCA Program. I also affirm that my questions regarding the program have been answered to my satisfaction.

Signature of participant: ___________________________________ Date: ______________

FOR INFORMATION PURPOSES ONLY

# AUTHORIZATION FOR
# USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize the Twin Rivers YMCA located at 100 YMCA Ln. New Bern, NC to collect and use data in connection with my participation in the LIVE**STRONG** at the YMCA Program, maintain this data in a data capture system, and disclose (i.e., share) this data to the YMCA of the USA (Y-USA) located at 101 N. Wacker Drive, Chicago, IL 60606.

**Data/Information to be disclosed**:
Health information collected in connection with the LIVE**STRONG** at the YMCA Program

**The purposes of the disclosure include**:

- Program administration, operation, and evaluation
- Research activities approved by an Institutional Review Board (IRB)
- To enter into the YMCA's data system for LIVE**STRONG** at the YMCA for purposes of tracking and verifying health outcomes related to the LIVE**STRONG** at the YMCA Program
- When applicable, to fulfill applicable grant reporting requirements. This may require the re-disclosure of de-identifiable and/or aggregate health information to a third-party, including government entities (e.g., the U.S. Centers for Disease Control and Prevention)

**By signing below**:

- I authorize the use and disclosure of my health information as described above for the purposes indicated.
- I understand I have the right to receive a copy of this authorization.
- I understand the YMCA will not condition my participation in the LIVE**STRONG** at the YMCA Program on my providing this authorization.
- I understand the YMCA may receive payment or compensation (generally in the form of grants) from Y-USA, and, in some cases, such grants may condition funds on the disclosure of health information to Y-USA.
- I understand that persons or entities that receive health information under this authorization may not be bound by privacy laws (such as the federal law called HIPAA or other state data privacy laws) that protect the health information and, as such, may share it with others without my permission, if allowed by applicable law. Except as explicitly stated in this authorization, Y-USA may not further disclose my health information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
- I understand that I may revoke this authorization at any time by submitting my revocation in writing to the YMCA, and the revocation will not affect information that has already been used or disclosed.
- If this authorization has not been revoked, it will terminate five (5) years after my completion of my last program, unless a shorter period is specified under state law.

Signature of participant: ________________________________ Date: _____________

FOR INFORMATION PURPOSES ONLY

# AUTHORIZATION FOR
# RELEASE OF INFORMATION TO HEALTH CARE PROVIDER

I voluntarily authorize Twin Rivers YMCA to release or disclose my protected health information related to my participation in the LIVE**STRONG** at the YMCA Program to my primary care physician and/or other individuals referenced below. I understand I have a right to receive a copy of this authorization, and the information disclosed pursuant to this authorization may be redisclosed by the person(s) listed below. I understand I am not required to sign this form to participate in the program and that I may revoke this authorization at any time by submitting my revocation in writing to the YMCA.

| Primary Care Physician Practice: | | |
|---|---|---|
| Physician Name: | | |
| Address: | | |
| City: | State: | Zip Code: |
| Phone Number: | Fax Number: | |
| Email: | | |

**Other individual(s)**

| Name: | | |
|---|---|---|
| Address: | | |
| City: | State: | Zip Code: |
| Phone Number: | Fax Number: | |
| Email: | | |

If this authorization has not been revoked, it will terminate five (5) years after your completion of your last program, unless a shorter period is specified under state law.

Signature of participant: ___________________________________ Date: ______________

**Recommendation for Chronic Condition Prevention & Management**
**Eastern Carolina YMCA**
**Send to secure fax: (252)638-3871**

***Y membership NOT required; programs are open to ANYONE who meet eligibility criteria**

- **18+ years old**
- **Strong personal desire and commitment to attend all classes**
- **Permission for LIVESTRONG staff to talk to health care team as needed**
- **Physically be able to participate in at least most activities**
- **Willingness to fill out the required forms**

**RECCOMENDING PATIENT TO:**

○ **LIVESTRONG (Cancer Survivor Exercise Program)**

☐ patient is living with or has completed cancer treatment
☐ cleared to exercise with no restrictions
☐ cleared to exercise with the following restrictions/recommendations (please attach restrictions)

**SECTION 1: PATIENT INFORMATION**

***First Name**_______________________________________

***Last Name**________________________________________

***Height** ___________ ***Weight** ______________

***Phone Number**________________________________ ***DOB**____________

***Address**____________________________________________________

***Email** ____________________________________________________

**Gender** ☐ Female ☐ Male

**Race/Ethnicity**
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ Hispanic/Latino of any race
☐ White

**SECTION 2: PROVIDER CONTACT INFORMATION**

*Provider Name (Please print) ________________________________________________________

*Name of Practice (Please print) ______________________________________________________

*Phone ___________________________ *Fax ____________________________

I (the provider) have obtained participant authorization to release information to the Eastern Carolina YMCA.

*Provider Signature __________________________________________________ *Date ______________________

# FAX REFERENCE FORMS TO: (252)638-3871

**Questions? Contact Teresa Tefft, Health and Wellness Director at 252-638-8799 or ttefft@trymca.org**

**Medical Clearance Form**

**Date:**

**Client's Name:** **Physicians' Name:**

**Client's Phone:** **Physician's Phone:**

**Client's DOB:** **Physician's Fax:**

Dear Doctor ________________________________,

Your patient ____________________________ has requested to participate **in** LIVE**STRONG** at the YMCA: A Cancer Survivor Exercise Program at the Eastern Carolina, Twin Rivers YMCA. At the start of this program your client will participate in a fitness assessment, including the 6 minute walk test, one repetition max test for upper and lower body, and balance and flexibility test.

Following the fitness assessment, your patient will partake in cardiorespiratory fitness, muscular strength and endurance, and flexibility and balance activities. A specific, individualized exercise program will be created for the participant based on the needs, interests and any recommendations you might have. The LIVE**STRONG** program is designed to start easy and become progressively more difficult over a 12 week period. All fitness assessments and exercise activities will be administered by qualified personnel trained in conducting exercise test and exercise programs.

Based on the LIVE**STRONG** at the YMCA intake form, your patient has indicated a diagnosed medical condition, coronary risk factor, and/or health condition that require a physician's clearance prior to participation in the LIVE**STRONG** at the YMCA program.

By completing the form below, you are not assuming any responsibility for our administration of the fitness assessment or exercise program. If you know of any medical or other reasons why participation in the LIVE**STRONG** at the YMCA program would be unwise for your patient, please indicate so on this form.

If you have any questions regarding the LIVE**STRONG** at the YMCA program, please call the program coordinator.

Program Coordinator: Teresa Tefft, Health and Wellness Director Phone (252-638-8799)
Return Fax (252-638-3871)

---

Physicians Report
My patient, listed above, is:
________Not cleared to exercise at this time
________Cleared to exercise with no restrictions
________Cleared to exercise with the following restrictions and/or recommendations

______________________________________________________________________________
______________________________________________________________________

Physicians Name: ___________________________________

Physicians Signature: ________________________________ Date: _____________