

**Institute for Human Performance  
Vitality Fitness Program  
Health Provider Approval Form**

Dear \_\_\_\_\_  
(Physician's Name)

The Vitality Fitness Program at the Institute of Human Performance offers aquatic and land based exercise programs. The program is designed to improve the health and wellness of people in our community. Goals for the program include: producing an improvement in participant's muscular strength, flexibility, cardiovascular endurance and self-esteem; providing a convenient, regularly scheduled opportunity for participants to exercise and socialize; and producing a positive influence on participants' overall quality of life. Each participant is given an initial assessment to review health history, current activity level, limitations, occupational, and other leisure time activities. This information is combined with the individual's personal goals to create an individualized exercise program based on guidelines provided by the American College of Sports Medicine (ACSM). All participants are required to obtain physician clearance to participate in the program.

The core components of the aquatic and land based exercise programs consist of warm-up, light strength training, flexibility/range of motion, cardiovascular, and cool-down components. The strength training component consists of 1-2 sets of 10-12 repetitions. The cardiovascular component consists of various activity or equipment at a target heart rate 60-80% of maximum predicted heart rate if appropriate. All activity is also monitored on the Borg Perceived Exertion Scale at a level of 11-13 (fairly light to somewhat hard).

If you have any questions concerning the program structure or components, please feel free to contact Carol Sames, Fitness Supervisor, at 464-9992.

It is my understanding that \_\_\_\_\_ will be participating  
(Participant's Name)  
in an exercise program. As the participant's health provider, I am not aware of any medical condition that would prevent him/her from participating in the program outlined above. Any restrictions are listed below.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Physician's Signature)

Restrictions \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please remit this form to the participant or fax to 464-9998

Participant's phone # to be contacted \_\_\_\_\_