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: Street 2: City: *** State:** *** ZIP Code:**
Home Phone: ( ) -	*** Mobile Phone:** ( ) -	
Email:		**Preferred Contact Method** *(select one)*: ☐ Email ☐ Mobile - Call ☐ 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 ☐ Doctor/Other Health Care Professional ☐ Employer ☐ Family/Fried/Word of Mouth ☐ Health Insurance Company ☐ Media/Marketing ☐ Screening Event/Health Fair ☐ Y Staff Member/Volunteer ☐ Other	☐ Less than high school ☐ High school diploma or GED ☐ Associate degree ☐ Bachelor's degree ☐ Master's degree ☐ Doctorate ☐ Professional degree (MD, JD, DDS, etc.) ☐ Other	☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White or Caucasian ☐ A race not listed here ☐ Prefer not to answer
*** Are you of Hispanic, Latino(a), or Spanish Origin?** ☐ Yes ☐ No ☐ Prefer not to answer	**Are you a member of the Y?** ☐ Yes ☐ No	**Employer Name:** _____

YMCA Staff Use ONLY:

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

Updated 10/2019

HEALTH INFORMATION

Where were you treated?
Physician name:

Have you ever had any of the following health conditions?	
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):

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 ☐ Right Upper Extremity

☐ Left Upper Extremity ☐ Right Lower Extremity

☐ Left 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

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?

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 _____ 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 contact the program coordinator.

Program Coordinator: Mary Chase, Health Innovations Coordinator
Email: HealthyLiving@ymcaswfl.org
Phone: 941 492 9622 ext. 299
Fax: 941 496 8028

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: _____

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. 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 exercise. I understand that I am responsible for monitoring my own condition throughout the exercises 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 the program 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 exercise, 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: _____

AUTHORIZATION FOR
USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize the SKY Family YMCA (YMCA) located at 701 Center Road, Venice FL 34285 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
- To transfer to REDCap Online Data Collection System 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 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 that I have the right to receive a copy of this authorization
- I understand that the YMCA will not condition my participation in the LIVE**STRONG** at the YMCA Program on my providing this authorization
- I understand that 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: _____

AUTHORIZATION FOR
RELEASE OF INFORMATION TO HEALTH CARE PROVIDER

I voluntarily authorize The SKY Family YMCA (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 that 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 that 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: _____

Association: Branch:

LIVESTRONG® AT THE YMCA PROMIS-29 PROFILE

VERSION 1.0

Participant name:	Date (MM/DD/YY): / /	Timepoint: ☐ Baseline ☐ Post

Please respond to each question or statement by marking one box per row.

	PHYSICAL FUNCTION Are you able to...	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
1	Do chores such as vacuuming or yard work?	☐	☐	☐	☐	☐
2	Go up and down stairs at a normal pace?	☐	☐	☐	☐	☐
3	Go for a walk of at least 15 minutes?	☐	☐	☐	☐	☐
4	Run errands and shop?	☐	☐	☐	☐	☐

	ANXIETY In the past 7 days...	Never	Rarely	Sometimes	Often	Always
5	I felt fearful	☐	☐	☐	☐	☐
6	I found it hard to focus on anything other than my anxiety	☐	☐	☐	☐	☐
7	My worries overwhelmed me	☐	☐	☐	☐	☐
8	I felt uneasy	☐	☐	☐	☐	☐

	DEPRESSION In the past 7 days...	Never	Rarely	Sometimes	Often	Always
9	I felt worthless	☐	☐	☐	☐	☐
10	I felt helpless	☐	☐	☐	☐	☐
11	I felt depressed	☐	☐	☐	☐	☐
12	I felt hopeless	☐	☐	☐	☐	☐

	FATIGUE In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
13	I feel fatigued	☐	☐	☐	☐	☐
14	I have trouble starting things because I am tired	☐	☐	☐	☐	☐
15	How run-down do you feel on average?	☐	☐	☐	☐	☐
16	How fatigued did you feel on average?	☐	☐	☐	☐	☐

	SLEEP DISTURBANCE **In the past 7 days...**	Very poor	Poor	Fair	Good	Very good
17	**My sleep quality was**	☐	☐	☐	☐	☐
	In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
18	**My sleep was refreshing**	☐	☐	☐	☐	☐
	In the past 7 days...	Not at all	A little bit	Somewhat	Quite a bit	Very much
19	**I had a problem with my sleep**	☐	☐	☐	☐	☐
20	**I had difficulty falling asleep**	☐	☐	☐	☐	☐

	SATISFACTION WITH SOCIAL ROLE **In the past 7 days...**	Not at all	A little bit	Somewhat	Quite a bit	Very much
21	**I am satisfied with how much work I can do (include work at home)**	☐	☐	☐	☐	☐
22	**I am satisfied with my ability to work (include work at home)**	☐	☐	☐	☐	☐
23	**I am satisfied with my ability to do regular personal and household responsibilities**	☐	☐	☐	☐	☐
24	**I am satisfied with my ability to perform my daily routines**	☐	☐	☐	☐	☐

	PAIN INTERFERENCE **In the past 7 days...**	Not at all	A little bit	Somewhat	Quite a bit	Very much
25	**How much did pain interfere with your day to day activities?**	☐	☐	☐	☐	☐
26	**How much did pain interfere with work around the home?**	☐	☐	☐	☐	☐
27	**How much did pain interfere with your ability to participate in social activities?**	☐	☐	☐	☐	☐
28	**How much did pain interfere with your household chores?**	☐	☐	☐	☐	☐

	PAIN INTENSITY **In the past 7 days...**	No pain										Worst imaginable pain
29	**How would you rate your pain on average?**	0	1	2	3	4	5	6	7	8	9	10