VISITING NURSE ASSOCIATION
OF CAPE COD
Member Cape Cod Healthcare

Walking Program
Medical Clearance Form

Dear Medical Provider:

This program is a supervised walking group that meets twice a week. Participants will need to walk at a slow to moderate pace for one (1) hour and approximately one to one and a half (1-1.5) mile(s)

Some of the goals of this program are:

- **Improve physical endurance and balance**
- **Build lower extremity strength**
- **Improve psychological health**

Please complete the following:

I am not aware of any condition(s) that preclude the participation of _____ (Patients Name)
DOB _____ in the walking program.

Patient was examined on or last seen:_____

Are there any limitations for participation? ☐ Yes (please specify below) ☐ No

_____

_____

Types of medication taken, history of cardiovascular disorders, diabetes, orthopedic problems, respiratory problems, convulsive disorders, etc. that may affect the participation in the walking program?

_____

_____

_____

(MD Signature) **Date** **(MD printed name)**

Address: _____

Phone: _____ Fax:_____

For more information/questions regarding walking program, Please contact Amy Chipman at VNA Public Health and Wellness, 508-957-7423. This form may be faxed to: 508-394-2109