Healthy Families & Communities
Shawano County Courthouse
Room 101, 311 North Main Street
Shawano, WI 54166
Fax: 715-526-4875

The Strong Bones Program

Thank you for participating in the Strong Bones Program. We have reviewed your registration forms for the Strong Bones Strength Training Program. Because you answered "YES" to one of the questions on the PAR-Q & You questionnaire or you are over the age of 70 the program requires a Physician Authorization Form to be completed by your Doctor.

I have enclosed a letter for your doctor and the Physician Authorization Form for your doctor to fill out. Please have this completed as soon as possible before the start of class.

Sincerely,

Kara Skarlupka

Kara Skarlupka
Healthy Families & Communities
Coordinator

Healthy Families & Communities
Shawano County Courthouse
Room 101, 311 North Main Street
Shawano, WI 54166
Fax: 715-526-4875

The Strong Bones Program

Date:_____

Dear Dr. _____,

Your patient _____, is interested in participating in the Strong Bones Strength Training Program through the Shawano County Healthy Families and Communities Program. This moderate intensity, progressive exercise program includes strength and balance training and is designed to improve muscle strength dynamic balance, and flexibility.

This program is based upon the results of strength training studies in older adults conducted by; scientist at the John Hancock center for Physical Activity and Nutrition at the Gerald J. and Dorothy R. Friedman School of Nutrition Science and Policy at Tufts University, Boston, MA. Scientists and exercise physiologists at Tufts University have designed this exercise program especially for midlife and older adults, and Program Leaders in your community are implementing the program. Your patient will be required to complete a Medical History Questionnaire and provide Informed Consent prior to participation in this exercise program.

Please complete and sign the enclosed Physician Authorization Form. If you have any questions or would like to discuss your patient's participation in this program in further detail, please call Kara Skarlupka at 715-526-4863.

Kara Skarlupka

Kara Skarlupka
Healthy Families & Communities Coordinator

Physician Authorization Form

Patient Name: _____

Address: _____

_____

Phone Number: _____Date of Birth: _____

Date of Last Exam: _____

Height: _____Weight: _____ Pulse: _____ BP: _____

Other: _____

Medical Conditions: _____

Medications: _____

_____

Special Considerations: _____

_____

_____

_____Yes, my patient can participate.

_____ No, my patient cannot participate at this time due to his/her medical conditions and health status.

Physician's Signature: _____

Print Name:

_____

Address:

_____

Phone Number: _____FAX Number: _____