Challenge Diabetes Program
Safe Exercise Assessment Form

To be completed by your medical professional:

	Yes	No
Which type of diabetes does this patient have? Type 1____ Type 2____		
Does this patient take medications that may lower blood glucose levels?	___	___
If yes, does he/she know the symptoms and treatment of low blood glucose?	___	___
Does the patient have exercise limitations that a personal trainer should know about?	___	___

If yes, please explain:

To evaluate how effective the program has been we will compare your last A1c before beginning to the first one after. You agree to provide the first A1c after completion of the program for this purpose.

Patient's last A1c result _____ Date of test_____

_____	_____	_____
Medical Professional's Signature	Printed Medical Professional's Name	Date

_____	_____	_____
Participant's Signature	Printed Participant's Name	Date

Important: Please provide contact information for the patient:

Name _____

Address _____

Phone _____ Email _____

This form contains <u>confidential information</u> that must be returned in one of these ways:

- Email it to coordinator@challengediabetes.us
- Fax it to CDP, Att: Coordinator 413-567-5734
- Mail it to: CDP, P.O. Box 4655 Springfield, MA 01101

Do not drop it off or mail it to the YMCA