



Totally Teen Exercise and Weight Loss Program

Dear Parent:

**Our intensive 6-week all-inclusive program is designed exclusively for teens between the ages of 9-15.**

**It features:**

- **Medically-supervised age appropriate cardio & weight training**
- **Attention to healthy eating habits**
- **Nutrition counseling**
- **Behavior modification techniques**

**Body Fat analysis**

**Classes are held in our fully-equipped exercise gym, in the Cardiovascular Fitness Center at Mountainside Hospital, Montclair, NJ. The program fee is \$175. Medical Clearance is required from the child's physician.**

The Program will be held on Monday and Wednesday evenings for 6 weeks. Each participant will exercise for one hour twice a week from 6-7 p.m. The nutritional lecture dates will be determined.

The Medical Clearance, which must be completed and signed by your child's physician and should be instructed to fax it to us at 973-680-7741.

Once you have completed your child's Health History Questionnaire, please fax, e-mail or send it to us. **(Fax #973-680-7741 or e-mail to: [Diane.depadova@mountainsidehosp.com](mailto:Diane.depadova@mountainsidehosp.com))**

If you have any questions or would like to know the next start date, please feel free to call us at 973-429-6199.



**Totally Teen Weight Loss and Exercise Program**

**Name** \_\_\_\_\_ **Age** \_\_\_\_\_ **Date** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Risk Factors:** HTN\_\_\_\_ Obesity\_\_\_\_ Diabetes\_\_\_\_ Stress\_\_\_\_  
Hyperlipidemia \_\_\_\_\_

**Physical:**

Weight \_\_\_\_\_ Height \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Heart \_\_\_\_\_ Lungs \_\_\_\_\_

**Laboratory: if necessary**(Fill in or enclose reports)

RBC \_\_\_\_\_ WBC \_\_\_\_\_ HB \_\_\_\_\_ HCT \_\_\_\_\_ HgbA1c \_\_\_\_\_

Chol \_\_\_\_\_ Trig \_\_\_\_\_ HDL \_\_\_\_\_ LDL \_\_\_\_\_ Chol/HDL= \_\_\_\_\_ LDL/HDL \_\_\_\_\_

**Medical Recommendations:**

Are there any special considerations or limitations to cardiovascular or weight training?

Yes \_\_\_ No \_\_\_ Explain \_\_\_\_\_

\_\_\_\_\_

This patient may participate in the Totally Teen program.

**Physician Name** \_\_\_\_\_

**Address** \_\_\_\_\_

**Phone Number** \_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature**



Do you exercise regularly? Yes \_\_\_\_ No \_\_\_\_ How Often? \_\_\_\_\_

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Have any members of your immediate family been diagnosed  
With Heart Disease? Yes \_\_\_\_ No \_\_\_\_ Explain: \_\_\_\_\_

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Do you have any physical limitations which should be considered before starting an exercise  
program? Yes \_\_\_\_ No \_\_\_\_\_

| Any History Of:                  | Yes   | No    |
|----------------------------------|-------|-------|
| Chest Pain, Pressure, Tightness  | _____ | _____ |
| Shortness of Breath              | _____ | _____ |
| Palpitation or Pounding of Heart | _____ | _____ |
| Dizziness                        | _____ | _____ |
| Heart Murmur                     | _____ | _____ |
| Heart Disease                    | _____ | _____ |
| High Blood Pressure              | _____ | _____ |
| High Cholesterol                 | _____ | _____ |
| Diabetes                         | _____ | _____ |
| Seizures                         | _____ | _____ |
| Asthma                           | _____ | _____ |
| Hernia                           | _____ | _____ |
| Orthopedic Problems:             |       |       |
| Spine, Disc or Lower Back        | _____ | _____ |
| Back, Joint or Muscular          |       |       |

Please elaborate on any Yes answers: \_\_\_\_\_

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What are your goals for this exercise program? \_\_\_\_\_

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