RWJBarnabas HEALTH | Robert Wood Johnson University Hospital Somerset

Community Health
110 Rehill Avenue
Somerville, NJ 08876-2598
Tel: 908-595-2345
Fax: 908-685-2535

STATEMENT OF MEDICAL CLEARANCE FOR EXERCISE

Participant Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

The above-named Participant would like to participate in the Community Health Department's exercise classes checked below. The Community Health Department at Robert Wood Johnson University Hospital Somerset coordinates these exercise classes, which have been specifically tailored for older adults. These exercise programs are comprised of balance, strength training, cardiovascular and/or flexibility activities. Please see other side of this form for class descriptions. If you would like additional information about any one of these classes, you may contact the Community Health Department at Robert Wood Johnson University Hospital Somerset at (908) 595-2345.

Aquacize _____ Fit Body, Fit Bones _____ Tai Chi _____

Chair Yoga _____ Zumba Gold _____ All of the Above _____

The above-named Participant will be required to complete a medical history questionnaire and to have their physician complete a Statement of Medical Clearance prior to participation in these exercise programs. Each participant will also be required to provide an Informed Consent prior to participation in these programs. In the event of adverse reactions to exercise, your Participant will be again required to request your consent before he/she can continue participation.

FOR COMPLETION BY PHYSICIAN:

I have reviewed the attached health history information on this Participant who is my patient and note that the Participant has no current medical problems that prohibit his/her from participating in the activities above. By signing below, I approve and support their participation in the exercise classes as selected above for the time period not to exceed one (1) year from the date of my signature, unless I advise in writing otherwise.

Comments/Special Considerations: _____

_____ _____
Physician Signature **Date**

Physician Information: **Name**: _____
NPI #: _____
Address: _____
Telephone: _____

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Exercise Class Descriptions

Fit Body, Fit Bones: A certified fitness instructor leads participants in weight-bearing exercises to strengthen muscles and bones to reduce the risk of fractures from osteoporosis. Peer leaders assist weekly in class instruction.

Aquacize: A certified water arthritis instructor teaches this water exercise program that soothes arthritis pain, strengthens joints and improves range of motion and lung capacity.

Zumba Gold: A certified group fitness and Zumba instructor leads these exercises, designed for all ages, that incorporate a variety of dance such as the Merengue, Cha Cha, Cumbia, Salsa, Belly Dance, Flamenco and Tango.

Tai Chi: An accredited Tai Chi instructor teaches the 19 movements and one pose in this ancient discipline. This class is ideal for beginning and returning students.

Chair Yoga: A certified yoga instructor leads participants in this ancient fitness routine that builds flexibility and strength and relieves pain associated with arthritis, carpal tunnel syndrome, migraines, back, and neck strain.

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MEDICAL HISTORY

Name: _____

Address: _____

Phone: _____

Emergency Contact: _____ Phone: _____

E-mail Address: _____

Please read the following list carefully and circle **YES or NO** as it applies to your medical history and current health, including any conditions for which you are currently receiving medical care.

Past Health History

Unstable cardiovascular diseases	YES	NO
Unstable diabetes	YES	NO
Hypertension (High blood pressure)	YES	NO
Rheumatoid or osteoarthritis	YES	NO
Stroke in the past 6 months	YES	NO
Surgery in the past 6 months	YES	NO
If yes, please specify type of surgery: _____		
Cataract surgery in the past 6 months	YES	NO
Broken bones in the past 6 months	YES	NO
If yes, where? _____		
Hernia	YES	NO
Abdominal aortic aneurysms	YES	NO
Heart condition	YES	NO
Has your doctor ever said that you should only perform physical activity recommended by a doctor	YES	NO

Current Health History (within the past month)

Chest pain or tightness, neck or jaw pain	YES	NO
Shortness of breath, indigestion, nausea, lightheadness	YES	NO
Heart palpitations	YES	NO
Discomfort from the waist up during exertion or activity	YES	NO
Pain or discomfort from the waist up when not doing physical activities	YES	NO
Joint pain	YES	NO
Muscle or back pain	YES	NO
New medications or dosage changes	YES	NO
Any other health or medical conditions	YES	NO

Please list: _____

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Participant Consent Form For Exercise Classes

I, _____, understand that I am participating in the exercise classes
(Print Name)

indicated on page one of this Medical Clearance Form voluntarily and at my own risk. I hold Robert Wood Johnson University Hospital Somerset, its Directors, Officers, employees and agents harmless from any and all liability for any harm incurred by me in connection with my participation in this program. There has been no change in my medical condition since my doctor signed a medical release form.

Print Name and DOB: _____

Sign Name: _____
(If participant is less than 18 years of age: Parent or Legal Guardian's must also print and sign below)

Date: _____

Legal Representative:

Print Name: _____

Sign Name: _____

Relationship to Participant: _____

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RWJUH SOMERSET COMMUNITY HEALTH DEPARTMENT

Authorization to Share "Protected Health Information" (PHI)

PURPOSE:

To permit the Community Health Department to respond to inquiries from peer leaders participating in the exercise program, and/or the instructor of any other exercise class in which I participate, regarding my Protected Health Information (PHI).

SECTION I Information regarding participant whose Protected Health Information is to be disclosed.

Name _____Date of Birth _____

Address_____

Daytime Phone_____ Evening Phone_____

SECTION II The person(s) with whom your information may be shared:

My information may be shared with:

- **Peer leaders in the exercise program who assist the fitness instructor with the exercises.**
- **The instructor of any exercise class in which I participate.**

SECTION III

This authorization will expire one year from the date of my signature below. Authorization is in effect up through the expiration date.

AUTHORIZATION

I hereby authorize RWJUH Somerset Community Health Department to share the following Protected Health Information concerning me:

- Identifying information (e.g., name, address, age, gender)
- Medical Clearance for Exercise form, and
- Medical History form.

I understand that my Protected Health Information will be shared with the peer leaders assisting the fitness instructor with the exercises, and/or the instructor of any exercise class in which I participate. This authorization is voluntary.

RIGHT TO REMOVE

I understand that I may cancel this authorization at any time by giving written notice to the Director of the Community Health Department. I further understand that cancellation of my authorization will not affect any action taken by the Community Health Department prior to receiving my written notice of cancellation.

SIGNATURE

Participant Signature_____ Date_____

(If participant is less than 18 years of age: Parent or Legal Guardian's name print and signature here)

Legal Representative:
Print Name: _____
Sign Name: _____Relationship to Participant: _____