Exercise Participant Form

Exercise and Falls Prevention Programs

- ☐ WALC group class
- ☐ SMART™ group class
- ☐ FAB FIT one on one
- ☐ SMART™ one on one
- ☐ Stand Up To Falls

Class Location

Participant Information

Surname | Given Name | How did you hear about us?

DOB (DD/MM/YYYY) | Home Telephone | Gender

Street Address | Unit Number

City | Postal Code | Other Phone | Email

☐ I would like to receive Community Support Connections' monthly e-newsletter to stay up to date on programs, events and more. My email address is provided above.

Emergency Contact Information

Surname | Given Name

Telephone Numbers (Home, Work, Cell) | Email | Relationship

Street Address | City | Postal Code

Primary Language: _____ **Mother Tongue:** _____

Preference: Primary ☐ Mother Tongue ☐

Consent and Liability Waiver

I am aware there are potential risks inherent in my participation in Community Support Connections' Exercise Programs (including: SMART™ Group Exercise, SMART™ One on One, WALC Group Exercise, FAB FIT One on One and Stand Up To Falls) due to the nature of the activity, and can occur without any fault. By choosing to take part in this activity, I am accepting the risk that I may be injured. I freely and voluntarily accept and assume all such risks and dangers.

I acknowledge that Community Support Connections offers no medical assessment or treatment and that Community Support Connections makes no determination as to whether or not I am physically fit to participate in their Exercise Programs. I hereby warrant that I am physically fit to participate in Community Support Connections' Exercise Programs.

I accept my responsibility to carefully follow instructions at all times while participating in Community Support Connections' Exercise Programs and to abide by all the rules set out by Community Support Connections' Exercise Programs.

I am aware that at any time I may decline to participate in part of, or in the entire Exercise Program. I accept full responsibility for my level of participation. I acknowledge my obligation to immediately inform the instructor of any pain, discomfort, fatigue, or any other symptoms that I may suffer during and immediately after my participation. I understand that I am encouraged to ask questions or request further explanation about Community Support Connections' Exercise Programs at any time.

I agree that SMART™, Community Support Connections, and VON shall not be liable for any injury to my person or loss or damage to my personal property arising from or in any way connected to my participation in Community Support Connections' Exercise Programs.

I acknowledge that I have read the above. I understand that in participating in the activity described above I am assuming the risks associated with doing so.

I understand that the emergency contact I have provided will be contacted by the agency when an incident or emergency occurs.

By signing below, I give my consent to Community Support Connections to keep and store my personal health information. I understand that the agency adheres to the Personal Health Information Protection Act (PHIPA), for the security of the information I am providing.

Signature of Participant **Date**

Community Support Connections

PAR-Q

VON CANADA
HEALTH STARTS AT HOME

Help us in delivering safe and effective physical activity for you by answering the following questions honestly:

YES	NO	Physical Activity Readiness Questionnaire (PAR-Q)
☐	☐	Has your doctor ever said that you have a heart condition **OR** high blood pressure?
☐	☐	Do you feel pain in your chest at rest, during activities of daily living **OR** when you do physical activity?
☐	☐	Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over breathing (i.e. vigorous exercise)
☐	☐	Have you ever been diagnosed with any other chronic medical condition other than heart disease or high blood pressure? List here: _____
☐	☐	Are you currently taking prescribed medications for a chronic medical conditions?
☐	☐	Do you currently have a bone, joint or soft tissue problem that could be made worse by becoming more physically active? Please answer **NO** if the problem was in the past and does not limit you currently. List here: _____
☐	☐	Has your doctor ever said that you should only do medically supervised physical activity?

If you answered **YES** to one or more of these questions, or if you are over 69 years of age and are not used to being physically active, please talk to your doctor **BEFORE** you start becoming more physically active.

Please speak with your doctor about the kinds of activities you wish to participate in and follow their advice. There is program information to share with your doctor on reverse of this page. You may be able to do any activity you want, as long as you start slowly and build up gradually. You may also need to restrict your activities to those which are safe for you.

_____ _____

Name of Participant (*please print*) **Date of Birth (dd/mm/yyyy)**

_____ _____

Signature **Date**

*** This side is for Physician use only ***

Your patient, _____, is interested in increasing their level of physical activity and will be participating in one or more of Community Support Connections' free gentle exercise programs (including: SMART™ Group Exercise, SMART™ One on One, WALC Group Exercise and FAB FIT One on One).

We believe it is important to work together with our participant's primary healthcare provider. Please review and provide any comments.

- ✓ Our instructors are certified by VON Canada's nationally accredited, evidence based, SMART™ Program.
- ✓ Each program is designed for a variety of needs and abilities, but each class includes the following components: cardiovascular, muscular strength and endurance, flexibility, and balance and coordination.
- ✓ There are **no** floor exercises.
- ✓ Exercises can be done from a seated or standing position.

Please check where applicable:

☐ I know of no reason why my patient should not participate

☐ I believe my patient can participate, but I urge caution in the following components:

☐ **Cardiovascular**

_____

☐ **Muscular strength and endurance (resistance training - weights, Thera bands)**

_____

☐ **Flexibility and range of motion**

_____

☐ **Balance and coordination**

_____

☐ I recommend that my patient **NOT** participate in the exercise programming.

Physician's Signature: _____ **Date:** _____