Fitness Center

Burke Rehabilitation Hospital l Adult Fitness Center
P: 914.597.2805 F: 914.597.2809
785 Mamaroneck Ave. White Plains NY 10605

The Burke Rehabilitation Hospital recognizes the need to stay physically fit at all ages and functional levels. The "Fit 4 Life After Stroke" exercise program provides an exercise setting for people who do not require ongoing medically prescribed physical or occupational therapy.

Fit for Life l After Stroke

This program offers exercise in an upbeat supportive group setting to meet the functional needs of all participants. This class meets the needs of individuals primarily at the wheel chair level, but who may also transfer and walk with assistance. The class takes place in the Burke Sports Center and participants will perform a variety of fun exercises for strengthening, flexibility, endurance and balance. Some exercise equipment will be used such as treadmills, NuSteps and resistance devices.

Session Information
Sessions are held quarterly, registration is ongoing.
Monday, Wednesday, and Friday
12:00PM – 1:00PM

How to Register

Check with your physical therapist for recommendation to this program
Attain physician approval
Return Forms and Payment to The Burke Adult Fitness Center
Program Fee: $255 for 3 months of participation.
Program fees can be paid monthly by credit card or in full at the start of the term by check made out to Burke Rehabilitation Hospital.

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COMMUNITY WELLNESS EXERCISE PROGRAM LIABILITY

I, _____ wish to join a community wellness exercise program at the Burke Rehabilitation Hospital. I understand that this is an exercise program involving a variety of physical activities that may include stretching, strengthening with weight training machines and devices; exercise on motorized and non-motorized exercise machines; walking within the Burke Rehabilitation Hospital Grounds. I understand that my participation is voluntary in this program.

I realize that the reaction of one's body to physical activity cannot be predicted with complete accuracy. There can be abnormal physical responses included, but not limited to changes in blood pressure, heart rate, dizziness and in rare cases serious illness such as heart attack or stroke. There is some risk of injury including, but not limited to, muscle strain, soreness and fatigue, I am willing to assume such risk.

In consideration of my participation in a wellness exercise class through the Adult Fitness Center at the Burke Rehabilitation Hospital, I for myself, my heirs, executors, administrators, representatives and assigns hereby discharge the Adult Fitness Center, Burke Rehabilitation Hospital, its employees, subsidiaries, affiliates, offices, directors , agents, successors, assigns and or representatives, for any and all claims, demands, causes of action, suites, charges, liabilities, and expenses (including attorney's fees) of any nature whatsoever, now or in the future, arising from my participation in these programs including but not limited to liability related to the injuries or illness listed above, however caused, whether they occur during or after my participation in these programs.

I hereby affirm that I have read and fully understand the above, and that my signing of this waiver is knowing and voluntary.

Date_____ Signature_____

Print Name_____

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FIT FOR LIFE EXERCISE PROGRAMS AT BURKE
PARTICIPANT HEALTH HISTORY AND PHYSICIAN APPROVAL

NAME_____ PHONE_____
ADDRESS _____CITY,ST, ZIP_____
EMAIL_____ D.O.B.___/___/___
EMERGENCY CONTACT: _____
PHONE:_____
PHYSICIAN_____ PHONE_____

PLEASE LIST: MEDICATIONS OR DIETARY SUPPLEMENTS YOU ARE CURRENTLY TAKING

1._____2._____3._____4._____
5._____6._____7._____8._____

HAVE YOU EVER HAD, OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS?
PLEASE CHECK ALL THAT APPLY

	DATE		DATE
☐High Blood Pressure	____	☐Osteoporosis	____
☐Stroke	____	☐ Arthritis	____
☐Congestive Heart Failure	____	☐ Diabetes	____
☐Heart Attack	____	☐ Cancer	____
☐High Cholesterol	____	☐ Low Back Pain	____
☐Aortic Stenosis	____	☐ Do You Smoke? Yes No	
☐Cardiovascular surgery	____	☐ PVD	____
☐Aneurysm	____	☐ Recent (1 year) Fracture	____
☐Cardiac Arrhythmia	____	☐ Pulmonary Hypertension	____
☐Recent Surgery	____	☐ Emphysema	____
☐ Oxygen Therapy Liters/Min	____	☐ Parkinson's Disease	____

HAVE THERE BEEN ANY COMPLICATIONS OR LIMITATIONS FROM ANY OF THE ABOVE CONDITIONS OR EVENTS WHICH MAY BE AGGRAVATED BY EXERCISE?

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Fit For Life Exercise Programs At Burke
Participant Health History and Physician Approval

This Fit for Life exercise class is not physical therapy; it is a regular exercise class meeting twice a week in which participants perform a variety of movements, stretches and some strengthening exercises to help improve function, reduce the effects of inactivity and help alleviate isolation.

Physician Approval For Participation

I give permission to my patient to participate in the Fit for Life exercise program at the Burke Rehabilitation Hospital.

Patient Name _____

Specific Limitations or Guidelines for Exercise:

_____

_____

_____.

Physician Signature: _____

Date:_____

Please fax completed form to 914-597-2809

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MEMBERS AGREE TO ACT IN ACCORDANCE WITH THE POLICIES OF THE BURKE FITNESS CENTER AS PROMULGATED FROM TIME TO TIME.

Violation of these rules may be the cause for suspension or cancellation of membership without refund. They include:

-Athletic attire and shoes in good condition should be worn at all times during exercise sessions.
No open toe or open back shoes.
-Proper hydration is essential before, during, and after exercise.
Cool water is available at the drinking fountain or at our vending machine in the main hospital.
-Please arrive on time: Classes begin with a warm-up prior to using equipment and cool down afterward.
-Stop exercise immediately if you feel discomfort or pain. Make staff aware.
-Members are responsible for informing the staff of their past and present health information that may have an effect on their exercise program.
-Do not use any piece of equipment without prior instruction from staff.
-Do not use any piece of equipment if it appears damaged or broken.
Please report any broken equipment to a staff member.
-Members are responsible for attending class, if class is canceled by the Burke Adult Fitness Center a makeup class will be offered or the subsequent session will be pro-rated to make up classes due to our cancelation.
-Refunds will not be available for missed classes. In the case of significant illness or injury, physician note must be provided indicating that the member is restricted from exercise due to illness/injury.
-Cell phones are not allowed in the exercise area, phone calls may be taken in the colonnade.
Please turn your phone off or on vibrate while exercising.
-Participants are expected to be courteous of each other and staff.
Courteous behavior includes, but is not limited to appropriate language and gestures.
-All Classes are 50 minutes long

I hereby affirm that I have read and fully understand the above, and that my signing of the program policy is knowing and voluntary.

Name (Printed): _____

Signature: _____

Date: _____