



**Fitness
Center**

Burke Rehabilitation Hospital | Adult Fitness Center

P: 914.597.2805 F: 914.597.2809

785 Mamaroneck Ave. White Plains NY 10605

FIT FOR LIFE EXERCISE PROGRAMS AT BURKE

Fit 4 Life Exercise Programs provide an exercise setting for people who do not require ongoing physical therapy or occupational therapy.

R.E.A.C.H. PROGRAM | FOR PARKINSON'S DISEASE

This Parkinson's exercise class is designed for the individual with a diagnosis of Parkinson's disease who can independently transfer and walk. R.E.A.C.H. stands for Range Exercise and Cardiovascular Health. This class is for graduates of Burke Outpatient LSVT-BIG program as an exercise continuation program. This class occurs in a group setting and incorporates full body exercise and cardiovascular training.

AVAILABLE SESSIONS- PLEASE CIRCLE ONE

SESSIONS RUN ON QUARTERLY BASIS- REGISTRATION ACCEPTANCE, ONGOING

Session One

Tuesday 2:00-2:45PM

And

Thursday 3:00-3:45PM

Graduates may only register for one of the two above sessions; classes cannot be individually purchased or combined in any fashion other than the above represented options.

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: *Introductory Price*\$170 for 3 months of participation.

Explanation of Payment: _____

Print Name _____ Signature for Payment _____

Payment Information:

Check for Full Amount

Credit Card: Visa/MasterCard/American Express

Card # _____ Expiration Date: _____



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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, suits, 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 _____



**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 |
|----------------------------------------------------|-------|---------------------------------------------------|-------|
| <input type="checkbox"/> High Blood Pressure | _____ | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Stroke | _____ | <input type="checkbox"/> Arthritis | _____ |
| <input type="checkbox"/> Congestive Heart Failure | _____ | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Heart Attack | _____ | <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> High Cholesterol | _____ | <input type="checkbox"/> Low Back Pain | _____ |
| <input type="checkbox"/> Aortic Stenosis | _____ | <input type="checkbox"/> Do You Smoke? Yes No | |
| <input type="checkbox"/> Cardiovascular surgery | _____ | <input type="checkbox"/> PVD | _____ |
| <input type="checkbox"/> Aneurysm | _____ | <input type="checkbox"/> Recent (1 year) Fracture | _____ |
| <input type="checkbox"/> Cardiac Arrhythmia | _____ | <input type="checkbox"/> Pulmonary Hypertension | _____ |
| <input type="checkbox"/> Recent Surgery | _____ | <input type="checkbox"/> Emphysema | _____ |
| <input type="checkbox"/> Oxygen Therapy Liters/Min | _____ | <input type="checkbox"/> 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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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 LSVT Classes are 45 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: _____