

## **BURKE FIT FOR LIFE PROGRAMS**

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Welcome to the Burke Fit for Life programs.

Thank you for considering Burke in making fitness a part of your life!

***Fit for Life exercise programs provide an exercise setting for people who do not require ongoing physical therapy or occupational therapy. A physician approval is required for all participants.***

### **Fit for Life | Parkinson's**

This program offers exercise in an upbeat supportive group setting to meet the functional needs participants. 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 may be used such as treadmills, NuSteps and resistance devices. This class is designed to reduce the effects of inactivity and alleviate feelings of isolation.

### **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.

### **FIT FOR LIFE | PULMONARY**

This pulmonary support group takes place in an active setting, where participants perform a variety of exercises for strengthening, flexibility, endurance and balance. Exercise is performed at tolerable levels and clients are encouraged to practice proper breathing techniques to decrease shortness of breath.

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**Fit For Life I Strength and Conditioning I**

The Strength and Conditioning exercise class is designed for the individual with an orthopedic or neurological history who can independently transfer and walk with an assistive device. A caregiver may be required to be present during the entire class.

**Fit For Life I Strength and Conditioning II**

The Strength and Conditioning exercise class is designed for the individual with a neurological history who can independently transfer and walk **with or without** an assistive device. A caregiver may be required to be present during the entire class.

**Fit for Life I 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.

**ENROLLMENT PROCESS**

1. Complete the attached forms and return to the Burke Adult Fitness Center.
2. Physician Approval: The member's doctor must complete page 5, Physician Approval for Participation. Your doctor's office can FAX your physician approval form to 914-597-2809.

**We encourage you to visit the facility and have all concerns addressed.**

**If you have any questions please call, 914-597-2805**

**We look forward to meeting you!**

**PARTICIPANT HEALTH HISTORY**

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?**

**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.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Print Name \_\_\_\_\_

**PROGRAM POLICIES**

**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.**

- 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.

Member's Name (Printed) \_\_\_\_\_

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_



REGISTRATION

Name \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ TODAY'S DATE \_\_\_\_\_
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_
PHONE \_\_\_\_\_ HOW DID YOU HEAR ABOUT US? \_\_\_\_\_
EMAIL \_\_\_\_\_ WOULD YOU LIKE TO RECEIVE EMAILS? [ ] YES [ ] NO
EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

CLASSES

- [ ] PARKINSONS Tuesday & Thursday 1-2p \$60.00 per month
[ ] LSVT - R.E.A.C.H. \$60.00 per month
Tuesday 2-2:45 & Thursday 3-3:45
[ ] PULMONARY Monday, Wednesday, Friday 1-2p \$65.00 per month
[ ] STRENGTH AND CONDITIONING 1 \$90.00 per month
[ ] STRENGTH AND CONDITIONING 2 \$60.00 per month
Tuesday, Thursday 11-12noon
[ ] STROKE \$90.00 per month
Monday, Wednesday, Friday 12-1p

X \_\_\_\_\_
Member Signature

[ ] CREDIT CARD # \_\_\_\_\_ EXP DATE \_\_\_\_\_

Your credit card will be charged monthly. It is the member's responsibility to inform Burke Adult Fitness of any changes to your credit on account.

=====OFFICE USE=====
Trans Listing \_\_\_ Type \_\_\_ Stat \_\_\_ JOIN \_\_\_ Calen \_\_\_ Exp \_\_\_ User \_\_\_ Drft \_\_\_ Repet \_\_\_ Modify Rep \_\_\_ Rond \_\_\_

## PHYSICIAN APPROVAL

Patient's Name \_\_\_\_\_ Patient's Phone \_\_\_\_\_ Date \_\_\_\_\_

This Fit for Life exercise class is not physical therapy; it is a regular exercise class meeting two or three times 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 (please print) \_\_\_\_\_

Specific Limitations or Guidelines for Exercise:

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Physician Name (please print) \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE FAX COMPLETED FORM TO 914-597-2809**