

PFNCA Exercise Programs at The Virginian

PFNCA is grateful for the support of The Virginian for hosting a number of PFNCA programs for people with Parkinson's.

In order to attend PFNCA exercise programs at The Virginian, there is a two-step process:

1. Register with PFNCA by visiting www.parkinsonfoundation.org or by calling (703) 734-1017 to receive your PFNCA name badge.
2. Complete the attached paperwork, which includes:

Check when completed	Document	Action Needed
	Registration Form: Fitness Classes at The Virginian	Complete
	Exercise and Fitness Facilities and Programs Waiver of Liability	Complete and sign
	Personal Health History Form	Complete and sign
	"Dear Dr." Letter	Have your Physician complete this letter and sign

3. Return Virginian Registration Packet to and direct questions to:

Maria L. Malca, Fitness Center Manager

The Virginian

Phone: 703-385-0555 x 5290

Fax: 703-385-0161

Cell: 703-966-0363

mmalca@thevirginian.org

You will be contacted by the staff at The Virginian once your paperwork is complete and processed.



REGISTRATION

FITNESS CLASSES AT THE VIRGINIAN

PLEASE RETURN THE COMPLETED PACKET TO THE FRONT DESK

NAME: _____

ADDRESS: _____

PHONE: _____

E-MAIL: _____

How did you hear of the exercise/fitness opportunity at The Virginian?

Were you referred for the Parkinson Wellness programs? _____

EMERGENCY CONTACT: _____

EMERGENCY CONTACT PHONE: _____

VEHICLE LICENSE: _____

PHYSICIAN'S NAME: _____

PHYSICIAN'S PHONE: _____

DATE TURNED IN TO FRONT DESK: _____

BACKGROUND CHECK: _____ STAFF INITIALS _____

**PLEASE NOTE: NON-RESIDENTS ATTENDING FITNESS CLASSES
MUST BE 65 YEARS OR OLDER.**

**EXERCISE AND FITNESS FACILITIES AND PROGRAMS
WAIVER OF LIABILITY**

This Waiver of Liability is part of the consideration between The Temple Foundation, Inc. t/a The Virginian (the Company) and _____ (Client) for Client's use of the Company's Exercise and Fitness Facilities and Programs (EFFP). The Client hereby agrees that use of the Company's EFFP is strictly at the Client's own risk. The Company, its agents, officers, employees, subcontractors, and directors, shall not be liable, in any way, for any claims arising from personal injuries or damage to property sustained by the Client in, on, during, or about the Companies EFFP. For the purposes of this Waiver of Liability, the Company's EFFP shall encompass all locations and activities reasonably utilized by the Company while providing health and fitness instruction and/or opportunities to the Client.

The Client hereby acknowledges that exercise is a strenuous activity and hereby warrants that the Client will not undertake to perform any exercises or motions which may endanger the Client's health and physical well-being. The Client is responsible for discussing a health and exercise routine with his or her personal physician. The Company makes no representations or warranties regarding the suitability of provided EFFP for any one client.

Should the Client file suit to recover for a personal or a property injury which is waived by this Waiver of Liability, then the Company is entitled to recover from the client all attorney's fees and costs incurred in the defense of any such action. The Company hereby retains the right to forbid any client from utilizing the EFFP at the Company's discretion.

THE VIRGINIAN

By: _____

Date: _____

Client: _____

Date: _____

PERSONAL HEALTH HISTORY FORM

NAME: _____ **DATE:** _____

SEX: _____ **AGE:** _____ **PHONE:** _____

ADDRESS: _____

What is the present state of your general health? _____

Does your physician know you are planning to participate in an exercise program? _____

Physician's name: _____ **Physician's phone#:** _____

Are you presently taking any medications? Please list? _____

Emergency contact: _____ **Phone#:** _____

Do you now or have you had within the past year:	YES	NO
1. History of heart problems?	_____	_____
2. High blood pressure?	_____	_____
3. Difficulty with physical exercise?	_____	_____
4. A chronic illness?	_____	_____
5. Advice from a physician not to exercise?	_____	_____
6. Muscle, joint, or back disorder that could be aggravated by physical activity?	_____	_____
7. Recent surgery (within the past two months)?	_____	_____
8. History of lung problems?	_____	_____
9. History of diabetes?	_____	_____
10. Cigarette-smoking habit?	_____	_____
11. Obesity (more than 20 pounds overweight)?	_____	_____
12. High blood cholesterol?	_____	_____
13. History of heart problems in immediate family?	_____	_____

What regular physical activity do you presently do? _____

To the best of my knowledge, all of the above information is correct.

Participant signature: _____ **Date:** _____

The Virginian

Date: _____

Dear Dr. _____.

Your patient, _____, has expressed an interest in participating in *The Virginian's* fitness program. An exercise program will be designed to meet his/her fitness goals, and may include the following modes of exercise: cycling, treadmill walking, NuStep or elliptical trainer, strength training, and/or group fitness classes. A qualified staff member supervises both the fitness center and group fitness classes.

If your patient is taking medications that will affect his/her heart rate response to exercise, please indicate the medication and its effect (increases or blunts heart rate response).

Medication:

Effect:

Please identify any recommendations or restrictions that are appropriate for your patient in their exercise program:

Thank you for your prompt attention to this matter.

Sincerely,

Maria L. Malca
Fitness Manager

_____ has my approval to exercise in *The Virginian's* fitness program with recommendations stated above.

Physician's Signature

Date