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:

<table>
<thead>
<tr>
<th>Check when completed</th>
<th>Document</th>
<th>Action Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Registration Form: Fitness Classes at The Virginian</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Exercise and Fitness Facilities and Programs Waiver of Liability</td>
<td>Complete and sign</td>
</tr>
<tr>
<td></td>
<td>Personal Health History Form</td>
<td>Complete and sign</td>
</tr>
<tr>
<td></td>
<td>“Dear Dr.” Letter</td>
<td>Have your Physician complete this letter and sign</td>
</tr>
</tbody>
</table>

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: ____________________________
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 ________________

9229 Arlington Boulevard, Fairfax, Virginia 22031
Phone: (703) 385-0555   Fax: (703) 591-9368   Website: www.thevirginian.org