The ENDWRIGHT CENTER

A PROGRAM OF AREA 10 AGENCY ON AGING

POLICY FOR USE OF THE FITNESS EQUIPMENT

Area 10 Agency on Aging offers the opportunity for community members to participate in an exercise program at the Endwright Center. This individualized fitness program includes a variety of cardiorespiratory, stretching, and resistance exercises designed to improve overall health and fitness. The goal of this program is to develop and or maintain heart and lung function, body composition, flexibility, bone density, endurance, and muscular strength. Benefits of participating in the program may include, but are not limited to, weight control, decreased resting blood pressure, reduced cholesterol, reduced stress and anxiety, and improved sugar tolerance (diabetes control). After an initial evaluation by the Fitness Specialist, an individualized exercise program will be created.

Before meeting with the Fitness Specialist to have an individualized exercise program created, a physician's consent must be on file. You may not use any of the equipment offered at the Endwright Center without a physician's permission for you to exercise. This consent must be annually renewed for your personal health and safety. We also ask that prior to an individualized fitness plan being made there is an Emergency Contact and Medical History form on file for each participant.

Inherent risks are associated with any exercise plan. The possible discomforts associated with exercise include dizziness, light-headedness, slight chest discomfort, leg cramps, occasional (mostly harmless) irregular heartbeats, and high blood pressure. The risk of a heart attack, although extremely small (2 in 10,000), does exist. Individualized Fitness programs are designed to reduce these risks and discomforts as much as possible. It is important to remember there is a 30 minute recovery period after exercise during which the heart is under additional strain. During this time excessive cold and heat, extended walking, and smoking should be avoided. This strain on the heart can be prevented by warming up before exercise and cooling down after exercise for at least 5 minutes.

Muscle soreness is common 1-2 days after exercising, and should disappear within a few days. This soreness is common and should not interfere with normal daily activities. If you ever experience pain that does interfere with daily activities, or lasts for more than five days, please contact your physician and inform the Fitness Specialist on your next visit to the Endwright Center. This could be a strained or torn muscle, or a more serious issue resulting from previous orthopedic issues. To avoid an injury, you may not use any of the exercise equipment without first receiving a proper demonstration from the fitness specialist.

All participants of the Endwright Center's individualized fitness program must sign in when they enter the facility and sign out when they leave the facility. Participants are also required to locate their personal fitness plan and record their daily activities. This allows the Fitness Specialist to monitor each participant's progress or address any concerns. When progress is made, the Fitness Specialist can adjust the individualized program to meet each participant's needs.

RULES AND REGULATIONS FOR PARTICIPANTS

The Endwright Center is here for community usage and the guidelines discussed below are meant to help accommodate the needs of all individuals using the facility.

- No smoking or alcoholic beverages are allowed in the facility
- Eating is only allowed in designated areas
- Please refrain from wearing any fragrances as this may cause a serious reaction in some people
- The equipment may only be used when the Program Director, Fitness Specialist, or Center volunteer is present
- Youth and adults 50 years and younger may only use the Center during organized intergenerational activities
- Property and individuals in the Center must be respected. Responsible parties are subject to replacing damaged or stolen property. Individuals engaging in physical or verbal abuse will be immediately asked to leave.
- Use of the Center beyond the hours of operation or scheduled programs must be arranged with the Program Director and must follow Center guidelines

By signing below you agree to having read the above information and consent to our fitness policies. You are also agreeing to release the Endwright Center and Area 10 Agency on Aging from any claim which may arise from participation in Endwright Center or Area 10 activities. Any violation of this policy will result in immediate removal from the Endwright Center. Please also understand that in some circumstances we may ask that you not exercise because the risks may outweigh the benefits.

Participant's printed name _____ Date _____

Signature of participant _____

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PARTICIPANT INFORMATION

First Name _____ Last Name _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone (_____)_____ Cell Phone (_____)_____

Date of Birth ____/_____/_____ E-Mail Address _____

Emergency Contact

Name (first, last) _____ Relationship _____

Home Phone (_____)_____ Cell Phone (_____)_____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Other Information

How did you hear about the Endwright Center? _____

Would you like more information about volunteer opportunities at the Endwright Center? _____

Area 10 offers a variety of services to older adults. Would you be interested in any of the other programs offered by the Agency? _____

In what types of programs would you be interested in participating?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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MEDICAL HISTORY / HEALTH HABIT QUESTIONNAIRE

Name_____ Age_____ Date of Birth _____

Address_____ City/State/Zip _____

Home Phone_____ Cell Phone_____

HOSPITALIZATION HISTORY

Age at Hospitalization	Reason for Hospitalization	Duration of Stay	Comments

CHILDHOOD DISEASES

Disease	Age

CURRENT MEDICATIONS

Medication	Purpose	Dose	How Often?

FAMILY HISTORY OF HEART DISEASE/STROKE

Indicate immediate family members (parents, siblings, aunts, uncles) who have diagnosed heart disease/stroke and/or who have died from heart disease/stroke.

Relationship	Type of Disease	Age at Diagnosis	Age at Death

HIGH BLOOD PRESSURE

Have you ever been told you have high blood pressure? ☐ Yes ☐ No If so, when? _____

Was any treatment recommended? ☐ Yes ☐ No If so, what? _____

Are you still undergoing treatment? ☐ Yes ☐ No If no, when did you stop? _____

List any family members who have/have had high blood pressure:

Relationship	Age at Diagnosis

DIABETES

Have you ever been told you have diabetes? ☐ Yes ☐ No If so, when? _____

What type of diabetes were you diagnosed with? ☐ Type I ☐ Type II

Are you still undergoing treatment? ☐ Yes ☐ No If no, when did you stop? _____

List any family members who have/have had diabetes:

Relationship	Type I or Type II?	Age at Diagnosis

CARDIOVASCULAR

Have you ever experienced chest discomfort, skipped heart beats, rapid heart rate or other arrhythmias? ☐ Yes ☐ No

If so, when? _____

Describe the nature of the discomfort. _____

What were you doing at the time? _____

When does it disappear? _____

Was medical advice sought? ☐ Yes ☐ No

What type of evaluation was performed? _____

What was the result / conclusion of this evaluation? _____

MUSCULAR / SKELETAL PROBLEMS

Do you currently or have you had in the past any muscular or skeletal problems? ☐ Yes ☐ No

If so, what? _____

If so, when? _____

Does this limit your ability to exercise? ☐ Yes ☐ No

Has medical advice been sought? ☐ Yes ☐ No

What was the result / conclusion of this evaluation? _____

PHYSICAL ACTIVITY

Are you presently engaging in any type of physical activity? ☐ Yes ☐ No

Type of Exercise	How Long (min)	How Often (days/week)	How Hard (light/moderate/hard)	When did you start?

Have you engaged in any type of physical activity in the past? ☐ Yes ☐ No

Type of Exercise	How Long (min)	How Often (days/week)	How Hard (light/moderate/hard)	When did you start?	When did you stop?	Why?

BACKGROUND/DAILY ROUTINE

Occupation_____ Years at present work status? _____

If retired, what was your occupation? _____

Do you consider your day: ☐ Sedentary ☐ Moderately Active ☐ Heavy Work

How many hours do you spend sitting each day? _____

How many minutes do you walk each day? _____

How many hours do you sleep each night?_____ Soundness of sleep: _____

Do you consider your day stressful? ☐ Yes ☐ No Why/Why not?: _____

Which meals do you eat? (check all that apply)

	Daily	Occasionally	Never
Breakfast			
Early morning snack			
Lunch			
Afternoon snack			
Dinner			
Bedtime snack			

Do you consider yourself overweight? ☐ Yes ☐ No If yes, how long have you been overweight? _____

How many pounds would you like to lose? _____

Do you smoke? ☐ Yes ☐ No If yes, how much and how often? _____

Have you smoked in the past? ☐ Yes ☐ No If yes, how much and how often? _____

How many years have you smoked? _____ When did you stop? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often? _____

Did you drink alcohol in the past? ☐ Yes ☐ No If yes, how much and how often? _____

How many years have you used alcohol? _____ When did you stop? _____

List any known allergies: _____

_____

Any additional pertinent information: _____

_____

Signature: _____ Date: _____

INTERVIEW NOTES

Client Name: _____

Interviewed by: _____

Date: _____

Comments:

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MEDICAL HISTORY ADDENDUM

Member First Name _____ Last Name _____

Phone Number _____ Date _____

Please have your physician sign the bottom of this form to verify your current medical and physical condition. This form will also act as an update to your initial physician's consent to exercise at The Endwright Center.

Indicate the change you would like to make to your medical history. Complete all information for each section you wish to update.

☐ **Hospitalization**

What was the reason for hospitalization? _____

_____

What was the duration of your stay? _____

☐ **Diagnosed with Hypertension (high blood pressure)**

Was any treatment recommended? _____

Are you currently undergoing treatment? _____

☐ **Diagnosed with Diabetes**

Was any treatment recommended? _____

Are you currently undergoing treatment? _____

☐ **Cardiovascular**

Have you experienced any chest discomfort, skipped heart beats, rapid heart rate or other arrhythmias? _____

What were you doing at the time of the incident, and when did the discomfort disappear?

_____

_____

Have you suffered from a heart attack or stroke? _____

Was medical advice given? _____

Are you currently undergoing treatment? _____

☐ **Muscular / Skeletal Problems**

Do you currently have a muscular or skeletal problem that inhibits or causes pain when performing any exercise activities? _____

Is this injury or inhibition the result of a specific incident? _____

_____

Was medical advice given? _____

Are you currently undergoing treatment? _____

☐ **Do you have any new known allergies?**

List your new allergies: _____

For office use only:

New exercise restrictions for this member: _____

_____

_____

Any additional comments pertaining to this member exercising at the Endwright center: _____

_____

_____

Was physician contacted? ☐ Yes ☐ No

Physician comments _____

_____

_____

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PHYSICIAN CONSENT FOR USE OF FITNESS EQUIPMENT

One of your patients, _____, has expressed interest in using the fitness equipment at our facility. In the best interest of your patient, we would like to confirm his or her current physical and medical condition with your consent.

If you have any restrictions pertaining to this patient exercising, please list them below:

If you have any recommendations or any other comments pertaining to this patient exercising, please list them below:

Signature of Physician _____ Date _____