Individualized Fitness Program Policy

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 fitness orientation by the Fitness Specialist, an individualized exercise program will be created. You may not use any of the equipment offered at the Endwright Center without meeting with the Fitness Specialist for a fitness orientation.

Prior to meeting with the Fitness Specialist, the following must be on file:

1) Medical history form
2) Physician's consent form
3) Emergency contact number

Continued Participation Requirements:

Participants are expected to inform us of any changes in health status. Each year, upon membership renewal, a medical history addendum form is required. Some health changes will necessitate getting an updated consent to exercise from your physician. This decision is made by the Endwright Center Director and/or Fitness Specialist, and is for your health and safety.

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. Any time an Endwright Center client displays symptoms of a potentially serious injury or possible medical incident (e.g. stroke, heart attack, etc.), Endwright Center personnel will call for emergency medical assistance. 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.

Participant's printed name ____ Date ____________________

Signature of participant ____

A PROGRAM OF AREA 10 AGENCY ON AGING

MEDICAL HISTORY

Name____ Date of Birth _______________________________________

PRIMARY CARE

Name of Physician__________________________________ Office Phone: ______________________________________

Do you give us permission to contact your physician? ____

RECENT HOSPITALIZATION HISTORY (past 2 years)

Age at Hospitalization	Reason for Hospitalization	Duration of Stay	Comments

CURRENT MEDICATIONS

Medication		Dose	How Often?

HISTORY/RISK OF HEART DISEASE/STROKE

Please list yourself and any immediate family members (parents, siblings, aunts, uncles) who have been diagnosed with heart disease/stroke and/or who have died from heart disease/stroke.

Relationship	Type of Disease	Age at Diagnosis	Age at Death

TURN OVER

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

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

Do you smoke or use any tobacco products? ☐ Yes ☐ No If yes, how much and how often? ____________________

Have you smoked (used tobacco products) in the past? ☐ Yes ☐ No If yes, how much and how often? ____________

How many years have you smoked (used tobacco products)? _______________________ When did you stop? ________

Have you ever been told you have asthma/respiratory health issue? ☐ Yes ☐ No

If yes, are you undergoing treatment? ☐ Yes ☐ No If no, when did you stop? _____________________________

What are your current cholesterol levels? HDL_____________ LDL_____________ Total _____________________

Do you have high triglyceride levels? Yes / No

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?____________________________________

MUSCULAR / SKELETAL PROBLEMS

Please describe any past or current orthopedic issues/injuries that may cause a concern or warrant further evaluation:

Lower extremities (foot, ankle, knee) ____

____

Mid (hips, spine) ____

____

Upper (shoulders, elbows, wrists, neck) ____

____

Other/cont. ____

Are you currently undergoing physical or occupational therapy for any of these issues? Yes / No

PHYSICAL ACTIVITY (past 6 months)

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

List any known allergies (including medications): ____

____

Any additional pertinent information: ____

*If any of your contact information changes, or if you have any new medical conditions/health incidents, please complete the proper addendum form so we may keep your file updated and as accurate as possible.

Signature: ____ Date: ____

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 ____________