PARKINSON'S WELLNESS PROGRAM

THE SKY FAMILY YMCA

www.swflymca.org

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

THE SKY FAMILY YMCA
PARKINSON'S WELLNESS PROGRAM
PARTICIPANT FORMS

Thank you for your interest in The SKY Family YMCA's Parkinson's Program.

The Pedaling for Parkinson's (PfP) class is a vigorous exercise program requiring participants to pedal a stationary bike at 80-90 revolutions per minute at heart rates between 60% - 85% of your maximal heart rate.

The Parkinson's Exercise Program (PEP) class is designed to help develop and maintain strength, flexibility, balance, and voice integrity. Conducted in a classroom using chairs, balls, bands and light hand weights the focus is on amplifying movements and improving gait, posture and speech.

Your safety is our first priority. In order to ensure that you are capable and qualified for the program(s) of your choice we need to collect some information about you. Enclosed please find:

Physician's Consent Form & Health Questionnaire

Health Innovations Guest Registration Form & Waiver

Target Heart Rate Calculation Sheet

When you have completed these forms please call 941-492-9622 ext 299 to schedule an Intake appointment.
Once all forms are completed and signed and you have met with the Parkinson's Coordinator you will be ready to begin taking classes

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Health Innovations Guest Registration Form & Waiver

Please print the following information *****Valid Photo ID Required***

Name____

Address___________________________________ City______________________________

State_____________ Zip Code______________ Date of Birth_______________________

Phone Number_______________________ Email Address____________________________

Program in which you are enrolled:

PD

Emergency Contact: _____________________________Phone Number________________

Driver's license or photo ID number____

WAIVER

EVERYONE PLEASE READ CAREFULLY AND SIGN.

I understand that the exercise will place an increasing workload on my cardio respiratory and musculoskeletal systems and there is a risk of physical changes during or following my exercise. I understand that failure to use the equipment properly may result in injury, illness, or medical problems including but not limited to fractured or broken bones, strained or torn muscles, tendons, or ligaments, dizziness, feeling light headed or becoming faint, stroke, heart attack, joint problems, or other physical problems.

I understand that I am responsible for monitoring my own condition throughout the exercise program and should any unusual symptoms occur, I will cease my participation and inform the fitness instructor, another YMCA professional staff member, or the front desk attendant.

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

I certify that I have no physical condition which would prevent me from safely engaging in an exercise program and agree to abide by all the rules and regulations of the Fitness Center.

In consideration for being allowed to participate in The SKY Family YMCA's exercise program, I agree to assume the risk of such exercise and inherent dangers from exercise and use of the equipment. I hereby release The SKY Family YMCA and its staff members and Directors from any and all claims, suits, losses, or related causes of action for damages related to my exercise program and hold them harmless from anything arising there from.

In signing this release and consent form, I affirm that I am legally capable of so acting, that I have read this form in its entirety, that I understand the nature of the exercise program.

_________________________________   _________________________________
Signature of participant   Printed name of participant

_________________________________   _________________________________
Date   YMCA staff witness

Staff Use Only – Please follow these instructions when registering:

1. Non-Members must complete the Health Innovation Guest Form and sign the waiver. Keep on file with other Guest Forms.
2. This program is set up as a one-time fee labeled Guest Pass - Pedaling for Parkinson's. Put the branch and the date in the description line - exactly like a regular guest pass.
3. Each visit will be recorded this way – 8 visits maximum.
4. Members do not need to register for this program.

Tour Given: Initials & Date: __________ Follow Up Call Made: Initials & Date: ________

Entered By: _______________

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Target Heart Rate Calculation

List any medications you are taking that may have an effect on heart rate:

____

____

____

You can calculate your target training heart rate using the Karvonen Formula. First you will need to determine your Maximum Heart Rate, your Resting Heart Rate and your Heart Rate Reserve.

1. Maximum Heart Rate = 220 – your age
   My Maximum Heart Rate is ________________ beats per minute

2. Resting Heart Rate = your pulse at rest (the best time to get a true resting heart rate is first thing in the morning before you get our of bed)
   My Resting Heart Rate is _________________ beats per minute

3. Heart Rate Reserve = Maximum Heart Rate – Resting Heart Rate
   My Heart Rate Reserve is _________________ beats per minute

Once you have your Heart Rate Reserve you can calculate your target training heart rate:

4. (Heart Rate Reserve x .85) + Resting Heart Rate = Upper end of training zone
   My Upper limit training heart rate is ______________ beats per minute

5. (Heart Rate Reserve x .60) + Resting Heart Rate = Lower end of training zone
   My Loweer limit training heart rate is _____________ beats per minute

6. My Target Heart Rate training range is ____________ - _____________ bpm

Parkinson's Wellness Programs at the SKY Family YMCA

Physician's Consent Form & Health Questionnaire

Fax to: 941-496-8028

<table>
<tr><td colspan="2">Participant Name:</td></tr>
<tr><td colspan="2">Date of Birth: Age: Circle: Male Female</td></tr>
<tr><td colspan="2">Address:</td></tr>
<tr><td colspan="2">Home Phone: Cell:</td></tr>
<tr><td colspan="2">Date of Diagnosis: Stage of Diagnosis: (Special considerations may be made for stage IV)</td></tr>
<tr><td rowspan="2">Circle the Program(s) of interest</td><td>Pedaling for Parkinson's</td></tr>
<tr><td>Parkinson's Exercise Program</td></tr>
</table>

To be completed by Physician

*Patient is eligible for participation if **ALL** of the following boxes are checked:*

- ❑ Patient has clinical diagnosis of Parkinson's Disease
- ❑ Graded at Hoehn and Yahr stage I, II, or III when off medication;
- ❑ Written clearance/permission by the physician for the PD patient to participate in the exercise program after the physician has been given a copy of the Standards. Clearance must address all concerns identified in the prescreening questions on back.
- ❑ I **recommend** that my patient participate in the Parkinson's Wellness Program

*Patient is ineligible for participation if **ANY** of the following boxes are checked:*

- ❑ Clinically significant medical disease that would increase the risk of exercise-related complications (e.g. cardiac or pulmonary disease, hypertension or stroke)
- ❑ Dementia as evidenced by a score less than 116 on the Mattis Dementia Rating Scale
- ❑ Other medical or musculoskeletal contraindications to exercise
- ❑ I **DO NOT** recommend that my patient participate in the Parkinson's Wellness Program

Please list and describe medications' effects on the patient's heart rate:

Beta Blockers:____

Stimulants:____

General Comments:______________________________________

____

____

Physician's Name Printed: _____________________________________

Physician's Signature:_______________________________________

Office Phone:______________________ Fax:________________________

Date:____

Pre-Screening Questions for Participant:	**Yes:**	**No:**
Have you taken any heart medications?		
Have you ever had a heart attack?		
Have you ever had heart surgery?		
Have you ever had heart failure?		
Have you ever had pacemaker/ implantable cardiac defibrillator/ rhythm disturbance?		
Have you ever had cardiac catheterization?		
Have you ever had coronary angioplasty?		
Have you ever had heart valve disease?		
Have you ever had congenital heart disease?		
Have you had a close blood relative who had a heart attack before age 55 (father or brother) or 65 (mother or sister)?		
Have you experienced unreasonable breathlessness?		
Do you take blood pressure medication?		
Are you a diabetic or take medicine to control blood sugar?		
Is your blood cholesterol >240 mg/dL?		
Females: Have you had a hysterectomy or are you postmenopausal?		
Have you experienced dizziness, fainting or blackouts?		
Do you smoke?		
Do you have musculoskeletal problems i.e. your doctor has recommended you not participate in exercise for muscular reasons?		
Do you have concerns about the safety of exercise?		
Are you physically inactive, exercising less than 30 minutes per day/ 3 days per week?		
Have you ever experienced chest discomfort with exertion?		