



"MEMBERS & FRIENDS HEALTHY TOGETHER" PROGRAM MEMBER CONSENT FORM

I, _____ (participant's name), do consent to participate in the "Members & Friends Healthy Together" Program. I do hereby acknowledge that I am participating in the program at my own will and at my own risk.

I understand that I have to be a current or former patient of physical, occupational, or speech therapy or athletic training at MRHC OR be invited by a member to join and participate in the program. **I AGREE THAT I AM 18 YEARS OF AGE OR OLDER.** I understand that I will be exercising on my own without direct supervision. I understand that the program may consist of stretching, strengthening with free weights, weight machines, or resistive band, cardio training, and aerobic training. As a current patient, I agree not to perform any exercises that may affect my progress with therapy unless instructed by my therapist or trainer to do so. I understand that if I am unable to set up and operate the machinery, I will bring a person who is capable with me to do so. I understand that current patients of the rehabilitation services have top priority to access the equipment. I understand that I must abide by the confidentiality standards set by MRHC, including not sharing any information regarding a patient's name or condition to anyone outside of the rehabilitation department.

I agree to have my physician or nurse practitioner sign a medical clearance form prior to my participation in the program. I agree to notify the rehabilitation staff of any significant medical history, complications, or restrictions that may affect my safe and independent participation in the program.

I AGREE TO NOTIFY THE REHABILITATION STAFF IF AT ANY TIME DURING AN EXERCISE SESSION I EXPERIENCE THE FOLLOWING: unusual pain or discomfort, shortness of breath, extreme fatigue, profuse sweating, rapid heart beat, headache, chest pain, muscle weakness, dizziness, calf pain or swelling, or any other unusual symptom. I understand that I need to contact my physician or nurse practitioner if any of these symptoms persist. I understand that it is my responsibility to check my blood sugar levels and/or blood pressure as indicated before and after participating in the program each session. I understand that I should not participate in an exercise session if my levels fall outside of the safe ranges set by my physician or nurse practitioner.



**"MEMBERS & FRIENDS HEALTHY TOGETHER" PROGRAM
MEMBER CONSENT FORM (CONTINUED)**

I understand that Magnolia Regional Health Center is not liable for any incurred injury or death to me during participation in the program or as a result of performing the program on my own.

I have read and understand the frequently asked questions handout. I have asked questions and have been given complete answers. I have a clear understanding of all of the information stated above.

MEMBER'S SIGNATURE

NAME PRINTED

DATE



**"MEMBERS & FRIENDS HEALTHY TOGETHER" PROGRAM
MEDICAL CLEARANCE**

VALID FROM DATE SIGNED TO DECEMBER 31, 2006

Dear Dr. / Mr. / Mrs. _____,

Your patient, _____, has applied for the "Members & Friends Healthy Together" Program. This program is designed for current or former patients of physical, occupational, or speech therapy or athletic training at MRHC. The members have the option of inviting one family member or friend to join with them as a member. All members must be over the age of 18 years old. The membership fee is \$30/month for members, \$30/month for friends, \$50/month for married couples and \$20/month for members who are current or retired MRHC employees. The members exercise independently, however rehabilitation staff members are always present during membership hours. The exercise program may include stretching, strengthening with free weights, weight machines, or resistive band, cardio training, and aerobic training. The member may be continuing an exercise program developed during therapy OR may choose to perform an overall body conditioning program. An orientation to the facility and equipment will be provided. In order to ensure member health and physical fitness, medical clearance from the applicant's physician or nurse practitioner is required. If your patient's medical status changes over the course of the year, it is your responsibility to withdraw medical approval of his/her participation.

Please check one of the following:

_____ The above named person is in good health and information currently available per our medical records suggests that he/she **CAN SAFELY AND INDEPENDENTLY PARTICIPATE** in the "Members & Friends Healthy Together" Program.

_____ The above named person **SHOULD NOT PARTICIPATE** in the "Members & Friends Healthy Together" Program since medical risks may outweigh the expected benefits.

_____ The above named person can participate in the "Members & Friends Health Together" Program, but must follow the stated **RESTRICTIONS/REQUIREMENTS:** (Comments must be supplied to check this option)



**"MEMBERS & FRIENDS HEALTHY TOGETHER" PROGRAM
MEDICAL CLEARANCE (CONTINUED)**

Additional Comments:

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

NAME PRINTED

DATE



"MEMBERS & FRIENDS HEALTHY TOGETHER" PROGRAM
MEMBER INFORMATION FORM

LastName: _____ First: _____ M.I. _____

Address: _____ City: _____ State: _____ ZipCode: _____

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

Employer: _____ Work Phone: (_____) _____

EmergencyContactPerson: _____ Relation: _____

EmergencyContactPhone:(_____) _____

FamilyPhysician: _____ Phone:(_____) _____

Medical History: (please check all that apply)

- Medical history checklist including: HIGH BLOOD PRESSURE, DIABETES, CANCER, PACEMAKER, HEART ATTACK, STROKE, ARTHRITIS/JOINT PROBLEMS, OSTEOPOROSIS, BACK PAIN, OTHER, RESPIRATORY/BREATHING PROBLEMS, THYROID PROBLEMS, HIGH CHOLESTEROL, HIGH BLOOD SUGAR, LOW BLOOD SUGAR, FIBROMYALGIA, VERTIGO/DIZZINESS, LOSS OF BLADDER CONTROL, LOSS OF BOWEL CONTROL, STOMACH PROBLEMS, HERNIA, HEART BYPASS, HEART STINT, OTHER STINT, BACK/NECK SURGERY, KNEE/HIP REPLACEMENT.

List of Medications:

Three horizontal lines for listing medications.



**"MEMBERS & FRIENDS HEALTHY TOGETHER" PROGRAM
MEMBER INFORMATION FORM (CONTINUED)**

List of Allergies: _____

Statement of Agreement/Decline Orientation to Rehab Clinic & Equipment

- I AGREE TO PARTICIPATE IN THE ORIENTATION PROGRAM PROVIDED.
- I DECLINE THE OPPORTUNITY TO PARTICIPATE IN THE ORIENTATION PROGRAM PROVIDED

SIGNATURE

DATE



"MEMBERS & FRIENDS HEALTHY TOGETHER" PROGRAM ORIENTATION CHECKLIST

TOUR OF FACILITY

- Clipboard Area
- Restrooms / Locker Rooms
- How to Fill Out Cybex Sheets
- Laundry Cart
- Break Room / Water Cooler
- Exits

DEMONSTRATION OF EQUIPMENT

CYBEX MACHINES

Upper Body

- Chest Press
- Chest Fly
- Triceps Curl
- Rowing
- Shoulder Press
- IR / ER Machine
- Lat Pull
- Biceps Curl

Trunk

- Abdominal Crunch
- Back Extension
- Torso Rotation

Lower Body

- Hip Machine
- Leg Press
- Leg Curl
- Squat / Heel Raise
- Leg Extension

CARDIOVASCULAR ACTIVITIES

- Recumbent Bikes
- UBE
- Stepmill
- Regular Bikes
- Stairstepper
- Arc Trainer
- Treadmills

MISCELLANEOUS EQUIPMENT

- Cable Column
- Theraband Station
- Dumbbells
- Weight Scales



**"MEMBERS & FRIENDS HEALTHY TOGETHER" PROGRAM
ORIENTATION CHECKLIST (CONTINUED)**

By signing below, I am stating that I understand what has been demonstrated to me as listed above. I agree to follow all rules and regulations of the MRHC Rehabilitation Services. I understand that patients of the rehabilitation services take priority, and I may be asked to move off of equipment that is needed for patient care.

MEMBER'S SIGNATURE

ORIENTED BY

DATE



"MEMBERS & FRIENDS HEALTHY TOGETHER" PROGRAM FREQUENTLY ASKED QUESTIONS

1. WHO CAN JOIN?

Any current or former patient of physical, occupational, or speech therapy or athletic training at MRHC may join as a member. A current or former patient may invite ONE friend or family member to join as a member with him/her. All members must be at least 18 years of age or older.

2. WHAT DOES MEMBERSHIP INCLUDE?

Membership includes access to the rehabilitation clinic gym during membership hours. As a member, you may participate in exercise including stretching, strengthening with free weights, weight machines, and resistive band, cardio training, and aerobic training. You will have access to the weight machines, treadmills, bikes, step-masters, step-climber, upper body bikes, arc trainer, free weights, resistive band, therapy balls, and therapy mats. You will NOT have access to equipment used specifically for therapy purposes including the pool, electrical stimulation units, ultrasound units, moist heat packs, cold packs, iontophoresis units, or the biodex training machine. An orientation to the clinic and equipment will be provided. Current patients will have top priority to the equipment. Therefore if you are using a machine, and the therapist or trainer asks to use the machine for patient care, you must allow them to use the machine.

3. WILL I BE SUPERVISED BY MEDICAL PERSONNEL?

No. There will always be a member of the rehabilitation staff present in the clinic during membership hours. However, you will be exercising on your own and at your own risk.

4. WHAT ARE MEMBERSHIP HOURS?

Membership hours are during open clinic hours:

Monday	7:00 a.m. - 6:00 p.m.
Tuesday	8:00 a.m. - 6:00 p.m.
Wednesday	7:00 a.m. - 6:00 p.m.
Thursday	8:00 a.m. - 6:00 p.m.
Friday	7:00 a.m. - 5:00 p.m.



“MEMBERS & FRIENDS HEALTHY TOGETHER” PROGRAM FREQUENTLY ASKED QUESTIONS (CONTINUED)

Membership hours are subject to change according to the rehabilitation’s hours of operation. A change in the schedule will be posted for members.

5. HOW MUCH DOES IT COST?

Members	\$30/MONTH
Member’s Friend	\$30/MONTH
Married Couples	\$50/MONTH
Members who are current or retired MRHC employees	\$20/MONTH

Membership dues are to be paid to Magnolia Regional Health Center at the first of each month. Dues may be given to Cindy Ganus, clerical coordinator. You will receive a receipt upon payment. There are no contractual fees. If you join after the middle of the month, the dues will be prorated for that month. Membership fees are subject to change.

6. WILL MY INSURANCE PAY FOR IT?

Most insurance companies do not pay for membership or health club fees. However, you may contact your insurance for more accurate information.

7. WHAT IS A CONSENT FORM?

You are required to sign a consent form prior to participation in the program. You must sign this form on a yearly basis.

8. WHAT IS A MEDICAL CLEARANCE FORM?

Your physician or nurse practitioner must sign a medical clearance form prior to your participation in the program. You may not join as a member unless your doctor has signed this form.