TOWNSHIP of HOPEWELL

MERCER COUNTY

DEPARTMENT OF HEALTH

201 Washington Crossing Pennington Road
Titusville, New Jersey 08560-1410

Public Health
Prevent. Promote. Protect.

Thank you for your interest in the Project Healthy Bones program. This program meets Mondays and Wednesdays at 10:45am in the Court Room of the Hopewell Township Municipal Building.

Each class is approximately one (1) hour in length. We encourage participants to attend all the sessions.

Enclosed are the following documents:

- Statement of Medical Clearance for Exercise
- Medical History
- Release Form

Above documents must be completed prior to the first class and returned to:

Township of Hopewell
Health Department/Healthy Bones
201 Washington Crossing Pennington Road
Titusville, NJ 08560

Confirmation of this program will be sent to you. If you have any questions, please call the Hopewell Township Health Department at (609)537.0236.

Sincerely,

Kathryn D. Richards, RNBS
Volunteer Lead Trainer
(609) 466.0366

PROJECT HEALTHY BONES

BALANCE & STRENGTH TO STAND TALL

Statement of Medical Clearance for Exercise

Patient Name: _____

Address: _____

Date of Birth: _____ Phone Number: _____

The above named patient would like to participate in Project Healthy Bones, an exercise and educational program designed to prevent and slow the development of osteoporosis. The program is led by trained Peer Leaders.

The program uses free weight equipment. Muscle exercises are designed to improve balance and strength using progressive ankle and hand weights. Weights begin with 1 lb. and progress as self-determined.

Project Healthy Bones is based on a program developed by the Massachusetts Department of Public Health and Action For Boston Community Development, INC. in consultation with the Nutrition and Exercise Physiology Laboratory at Tufts University. The program is sponsored by the NJ Department of Human Services, Division of Aging Services. For more information: www. state.nj.us/humanservices/doas/services/phb/index.html

_____ **YES,** I approve and support his/her participation in this progressive weight and balance training program.

_____ **NO,** my patient is not eligible to participate in this exercise program due to his/her current medical status.

_____ _____

Physician Signature Date

Physician Information:

Print Name: _____

Address: _____

_____

Telephone: _____

Please return completed form to your patient.

3/2012

Medical History

Name:_____Phone:_____

Address:_____

Family or friend to contact in an emergency:_____

Phone:_____ Cell Phone: _____

Please circle Yes or No as it applies to your medical history and current health, including any conditions for which you are currently receiving medical care.

Past Health History		
Unstable cardiovascular disease	YES	NO
Unstable diabetes	YES	NO
Unstable high blood pressure (hypertension)	YES	NO
Stroke in the past 6 months	YES	NO
Rheumatoid arthritis or osteoarthritis	YES	NO
Recent joint replacement, surgery or injury	YES	NO
Recent fall (last 6 months)	YES	NO
Injury as the result of a recent fall (last 6 months)	YES	NO
Broken bone in the past 6 months	YES	NO
Had a fall in the past 6 months	YES	NO
Cervical instability	YES	NO
Surgery in the past 6 months	YES	NO
Cataract surgery in the past 6 months	YES	NO
Hernia	YES	NO
Abdominal aortic aneurysm	YES	NO
Terminal illness	YES	NO
Has your doctor ever said that you have a heart condition?	YES	NO
Has your doctor ever said that you should only do physical activity recommended by a doctor?	YES	NO

Current Health History (in the past month)		
Chest pain or tightness, neck or jaw pain, indigestion, nausea, shortness of breath, lightheadedness, heart palpitations or any discomfort from the waist up during light exertion or activity	YES	NO
Any pain or discomfort from the waist up when not doing physical activity	YES	NO
Painful joint	YES	NO
Muscle pain or back pain	YES	NO
Any new medication or dosage changes	YES	NO
Unstable cardiovascular disease	YES	NO
Unstable diabetes	YES	NO
Unstable high blood pressure (hypertension)	YES	NO

Please provide us with any other medical conditions for which you have received treatment or been prescribed medication in the past:

_____

_____

Participant Agreement/Release

I, _____, understand and
(Print name)
confirm that my participation in this Healthy Bones Program is voluntary. I agree that during my participation I will exercise at a level that I am comfortable with, and I will stop exercising if it becomes uncomfortable, so as to prevent any illness or injury. I hereby release the New Jersey Department of Human Services, Morristown Medical Center, Lead Coordinators, Host Site, Peer Leaders and their officials, directors, members, agents, and/or employees from any liability or claims for personal injury or otherwise arising out of my participation in Project Healthy Bones.

_____ _____

Signature Date

Street _____ Town _____ Zip _____

Home Phone _____ Cell phone _____

E-mail _____

EMERGENCY CONTACT:

Name _____ Relationship _____

Home Phone _____ Mobile phone _____

3/2012

Enrollment Form and Waiver, April 2016

Participant to complete:

Name:_____

Adddress:_____

_____

Email:_____

Telephone:_____(C)_____

Contact person in case of emergency:_____

Phone: (H)_____(C)_____

Program Guidelines: Classes are open to any suitable person provided they are medically fit, are independently mobile, and can participate without assistance in the class.

Any participant, who has any doubt whether they are medically fit to attend the class, is required to have a medical clearance from their doctor prior to commencing.

Participants are required to do a gentle warm-up exercise before they start and a cooling-down exercises before finishing. These exercises are under the direction of the instructor.

Waiver:

I have read the Program Guidelines and I understand that there is an inherent risk in any exercise activities and I agree to abide by the rules set out in the Guidelines.

I know that there are no medical reasons why I should not participate in this class or workshop. I understand that if I do have any medical reasons why I should not participate in this class or workshop that it is my responsibility to obtain a clearance from my doctor before commencing.

Signature_____

Date:_____