Town of Fishkill Senior Injury Prevention Program
Progressive Weight Training Project

Doctor Consent Form

Dear Dr. _____,

Your patient, _____ has requested enrollment in an exercise program designed to reduce injury among older adults. Based on a pilot Osteoporosis Prevention Program undertaken with Miriam Nelson, Ph.D. from the Human Physiology Laboratory at Tufts University and the Massachusetts Department of Public Health, this program includes exercise, stretching and cool down.

The class consists of three one-hour sessions each week. The exercise component includes:

- Balance exercises
- Weight exercises with leg cuffs and hand weights, starting with 1LB pellets and increasing as participant feels able
- Strength exercises using body weight for resistance
- Overhead arm lifts

Ankle cuffs with removable pellets and one pound weights allow for individualizing the exercises for each participant and tailoring their progression with their comfort level. These exercises improve strength, flexibility and balance and may help to maintain bone density, all of which will help prevent falls and make broken bones less likely.

Your approval is required before participant can begin. Prior to starting the program, each participant will be evaluated by a primary physician for overall range of motion, muscle strength and functional status. In the event of adverse reactions to exercise, your patient will be required to again request your consent before he/she can continue participation.

I give consent for _____ to participate in a supervised progressive weight training program.
Comments/Restrictions:
_____
_____.

_____ _____

Signature Date

Town of Fishkill Senior Injury Prevention Program
Progressive Weight Training Project

Name_____ Date of Birth _____
Address_____ City _____ Zip _____

Phone _____ Insurance Info _____

Emergency Contact (Name & Phone) _____

Primary Physician _____ Phone _____

Medical History

Cardiovascular Disease	Yes	No
Diabetes	Yes	No
Hypertension	Yes	No
Osteoporosis	Yes	No
Rheumatoid Arthritis or Osteoarthritis	Yes	No
Stroke in the past 6 months	Yes	No
Surgery in the past 6 months	Yes	No
Cataract Surgery in the past 6 months	Yes	No
Fractured Bone in the past 6 months	Yes	No
Hernia or Abdominal Aortic Aneurysm	Yes	No
Memory Loss/Dementia Diagnosis	Yes	No
Lyme Disease	Yes	No
Chronic Dizziness	Yes	No
Significant Health Events (past 3 months)		
Chest pain or Tightness, Neck or Jaw Pain, Indigestion, Nausea	Yes	No
Shortness of Breath, Lightheadedness, Palpitations during exertion	Yes	No
Falling, Tripping	Yes	No
Dizziness	Yes	No
Painful Joints	Yes	No
Muscle Pain or Back Pain	Yes	No
Involuntary Weight loss or gain (+ or – 5 lbs)	Yes	No
Any new medications or dosages changes	Yes	No
Evaluation or Treatment of newly diagnosed condition	Yes	No
Under the care of a medical doctor, chiropractor, physical therapist, Or other doctor in the past 6 months	Yes	No

Legal Release: I will choose the level of activity which will not harm me. In consideration of my participation in this wellness/exercise program, I hereby release The Town of Fishkill from any liability or claims, for personal injury or otherwise, arising out of or in any way connected to my participation in this wellness/exercise program.

Signature_____ Date_____