HOLY CROSS HOSPITAL
Experts in Medicine, Specialists in Caring.

Participant & Provider Annual Information Release
Senior Fit

PARTICIPANT INFORMATION RELEASE

I understand that this physical fitness program is a group exercise activity that may include exercises to build the cardio respiratory system, (heart and lungs), and the musculoskeletal system (muscle endurance, strength, and flexibility). Exercises may include but are not limited to low impact aerobics, strength training, stretching, balance and coordination postures. Twice per year a fitness test is offered to measure progress. I acknowledge that all fitness tests undergone are done merely for informational purposes and do not declare my fitness, or lack of fitness for participation in the Sr. Fit program.

There are potential risks with any exercise program. I hereby certify that I know of no medical problems and accept any risk of illness or injury as a result of my participation in this exercise program. I understand that it is my responsibility to inform the class instructor(s) of any medical conditions(s) that I may have. Furthermore, I agree to wear appropriate exercise clothing and supportive athletic shoes to class. I understand that clogs, sling-back shoes, sandals and bare feet are not allowed.

I hereby release and hold harmless Kaiser Permanente, the site owner/operator of the exercise program; and Holy Cross Hospital of Silver Spring Inc., their agents, employees and independent contractors from any and all liability, damage, expense, causes of action, suits, claims or judgments arising from injury, damage or loss to me or my personal property which may arise from my participation in this exercise program.

Name:_____

Address:_____

City:_____ **State**:_____ **Zip Code**_____

Phone: (day)_____ **(evening)** _____

E-mail address:_____

Race (OPTIONAL) _____**Date of birth:**_____

Kaiser Permanente Member? YES / NO

SENIOR FIT LOCATION: _____**TIME OF CLASS:**_____

Emergency Contact Name_____Relationship_____

*Phone number _____ Cellular phone _____

Participant's signature: _____

*Please indicate which phone number you believe would be the most reliable emergency number at the time of your class. This number will be placed on your Senior Fit card.

PLEASE TURN PAGE FOR HEALTH PROVIDER CONSENT TO PARTICIPATE
(Both sides *must* be completed to participate)

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HEALTH PROVIDER CONSENT TO PARTICIPATE

Name of Patient:_____

I hereby consent to the participation of the above named individual in the senior exercise program. I am unaware of any medical or surgical condition(s), which the individual possesses which would be considered a contraindication to exercise.

Please note any recommendations or restrictions appropriate for your patient in this exercise program:

_____

Please check one: New Registrant Renewal

Participant e-mail: _____

(All fields Required)
Physician's name (printed or typed):_____

Physician's signature:_____

Date:_____**Physician's phone**:_____

Physician's Address:_____

City:_____**State:**_____**Zip:** _____

Rev. 01/03

Please mail this double-sided completed form to:

Holy Cross Hospital
Community Health
Senior Fit Program
1500 Forest Glen Road
Silver Spring, MD 20910