South Shore Health

South Shore Hospital
55 Fogg Road
South Weymouth, MA
SouthShoreHealth.org

Center for Physical Wellness
780 Main Street, First Floor
South Weymouth, MA
(781) 624-4367

PARTICIPANT WAIVER and INFORMATION FOR LAND and VIRTUAL CLASSES

If my application for the South Shore Health Center for Physical Wellness Community Exercise Program is accepted, I understand and agree that neither South Shore Hospital, nor its respective chapters, officers, directors, employees, agents, members or volunteers shall assume or have any responsibility or liability for expenses and medical treatment or for compensation for any injury I currently have or I may incur as a result of my participation in the program.

For all program participants, please review the information below:

- Please alert your instructor to any changes in medical status or medication.
- Please alert your instructor if you have difficulty or pain with any exercise.
- Please follow all prescribed individual program instructions as communicated to you by the Community Programs Team.
- Please follow COVID-19 guidance included herein.

I understand that the Program is not a therapy program. The Program is not medical treatment nor should it substitute for proper medical treatment. I also acknowledge that I am required to seek consultation from my physician about whether I can safely participate in this Program and whether there are any precautions or limitations to my participation. I give permission to my physician to complete the medical clearance form. The medical clearance form and health history form must be completed prior to my participation in the Program.

Payment is due the first week of each month. Checks and credit cards accepted. Check payments must be made out to South Shore Hospital. If you are paying by credit card, please call the Community Programs Receptionist at 781-624-4367 to process payment.

The Center reserves the right to limit participation of individuals when criteria are not met or the safety of participants, staff, or other group members is compromised.

Participant acknowledges that rules and guidelines may be subject to change due to the ongoing pandemic, COVID-19. Participant agrees to abide by all policies, guidelines, and procedures put into place by the Center for Disease Control ("CDC"), South Shore Hospital and the Center. Participants will be required to wear masks and practice social distancing in accordance with CDC guidelines. Participants will immediately inform the Center if they have been exposed or are experiencing symptoms and will not attend the Program or enter the facilities unless cleared by a medical professional and confirmed by the Center.

Participant Name (print): _____

_____ _____

Participant Signature Date

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Physician Clearance Form

South Shore Health's Center for Physical Wellness is offering a monthly land-based in person and/or virtual Community Exercise Program. Participants must be able to perform exercises without independently.

If this patient requires individualized attention, a physical therapy evaluation can be scheduled. A separate order is needed for this.

My patient, _____ DOB: _____, has medical clearance to attend The Center for Physical Wellness Community Exercise Programs.

Please indicate if there are any special precautions or response for this individual that may limit his/her participation in this program.

_____

_____

_____ _____

Physician Signature Date

Phone Number: (781) 624-4367
Fax Number: (781) 624-3518

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COMMUNITY PROGRAM HEALTH HISTORY FORM

Name: _____ DOB:_____

Street Address:_____

City/State/Zip:_____

Phone Number:_____

Home Alternate

In case of emergency, please contact:

Name:_____ Phone Number:_____

Relationship:_____ Alt. Phone Number:_____

Primary Care Physician: _____ Specialist: _____

Phone Number: _____ Phone Number: _____

Please list any allergies you have:

_____

Please check any of the following conditions that apply to you:

_____ Angina
_____ Blood Pressure
_____ Bowel/Bladder Problem
_____ Cancer (type):_____
_____ Chronic Bronchitis
_____ Congestive Heart Failure
_____ Coronary Artery Disease
_____ Diabetes
_____ Emphysema
_____ Hearing Problem
_____ Heart Attack
_____ Pacemaker/Defibrillator
_____ Seizures
_____ Vision Problem

Please list current medications, surgeries, and any other medical conditions that apply to you:

_____

_____

_____

_____

We ask that you alert your instructor to any changes in your medications or medical history.

_____ _____

Participant Signature Date

Updated December 2019