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 ______________________

Not-for profit, charitable, tax-exempt provider of acute, outpatient, home health, and hospice care to Southeastern Massachusetts
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.

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__________________________________________________________________________

Physician Signature                                               Date

Phone Number: (781) 624-4367
Fax Number: (781) 624-3518
COMMUNITY PROGRAM HEALTH HISTORY FORM

Name: ___________________________________ DOB: _____________

Street Address:______________________________________________________

City/State/Zip:________________________________________________________

Phone Number:_______________________________________________________

Home Alternante

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 ___________________ Diabetes

_____ Blood Pressure _____________ Emphysema

_____ Bowel/Bladder Problem _______ Hearing Problem

_____ Cancer (type):_______________ Heart Attack

_____ Chronic Bronchitis ___________ Pacemaker/Defibrillator

_____ Congestive Heart Failure ______ Seizures

_____ Coronary Artery Disease _______ 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

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