Thank you for your interest in **Senior Fit!** This program is designed for people who are 55 years of age and older, with a chronic condition and want to improve their health through exercise. We invite you to participate in this program sponsored by the Cadillac Area YMCA and Munson Healthcare Cadillac Hospital. Please let us know that you are interested by completing and returning the enclosed forms.

Classes are held on Tuesdays and Thursdays at the Cadillac Area YMCA Dillon Community Center. The times for the classes are 9:30, 11:00 and 1:30. We will schedule a one-on-one orientation and fitness testing session after we have received your application, health history forms, and physician referral. Each 60 minute exercise session consists of 30 minutes of instructor led exercises targeting aerobic endurance, muscular strength, flexibility, and balance and coordination, followed by 30 minutes of individual exercise time in the wellness center. No need to worry about your abilities, as each participant will be given an exercise program tailored to his or her specific needs by an Exercise Specialist. Cost for participation in the program is determined by income, and each participant's monthly contribution is likely to be **reduced or offered free of charge!**

Please complete the enclosed application and health information forms and return them to the YMCA. Also, be sure to mark the time you would like to attend. When we have received your application we will contact you to schedule an orientation session at your earliest convenience. If you have any further questions or concerns please call Nathanael Leftwich at (231) 775-3369.

Sincerely,

Nathanael Leftwich
Senior Fit Instructor

PLEASE RETURN TO: Nathanael Leftwich
Cadillac Area YMCA
9845 Campus Dr.
Cadillac, MI 49601

Senior Fit

CADILLAC AREA YMCA • DILLON COMMUNITY CENTER • MUNSON HOSPITAL CADILLAC

Physician Consent to Participate

Date ___/___/___

DR. _____

Your patient _____DOB___/___/__

has expressed interest in participating in Senior Fit, an exercise program for older adults with chronic diseases. The core components of the program include exercises to increase cardiovascular endurance, muscular strength, flexibility, balance, and coordination. Exercise sessions will be held on Tuesdays and Thursdays for a maximum duration of 60 minutes.

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

_____

_____

_____

_____

If you consent to his/her participation in this supervised exercise program, please indicate by signing your name below.

Signature _____ Date _____

Please give me the patient's phone number so I may reach them _____

Thank you for your time. As always, it is a pleasure being a partner with you in the care of your patients.

Sincerely,
Nathanael Leftwich, Senior Fit Instructor

PLEASE RETURN TO: Cadillac Area YMCA
Attn: Nathanael Leftwich
Fax: 231-775-4309

Senior Fit

Participant Information

Date _____

NAME _____ BIRTH DATE _____

ADDRESS _____

PHONE _____ ALERNATE PHONE _____

Emergency Contact (besides spouse) _____

ADDRESS _____

PHONE _____ ALTERNATE PHONE _____

Physician(s) _____

Are you currently employed? YES NO If yes – where? _____

Job Description: SEDENTARY LIGHT MODERATE HEAVY

Is your job limited by your condition? YES NO
If yes – please explain _____

_____

MEDICAL HISTORY (Please check all that applies to you)

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Heart Murmur
- ❑ Rheumatic Fever
- ❑ Kidney Disease
- ❑ Stroke
- ❑ Heart Attack
- ❑ Aneurysm
- ❑ Leg Cramps
- ❑ Arthritis
- ❑ Phlebitis
- ❑ Asthma
- ❑ Anemia
- ❑ Angina (chest pain)
- ❑ Bypass Surgery
- ❑ Shortness of Breath
- ❑ Back Problems
- ❑ Lung Disease
- ❑ Congestive Heart Failure
- ❑ Irregular Heart Beats
- ❑ Peripheral Vascular Disease
- ❑ Glaucoma
- ❑ High Cholesterol
- ❑ Angioplasty/Stent

Please list other conditions/surgeries not listed above: _____

_____

_____

_____

Allergies: _____

Smoking History: NEVER QUIT CURRENT _____packs/day

Alcohol Consumption: NEVER QUIT CURRENT _____drinks/day

MEDICATIONS (Please list all prescription/over-the-counter medications you are currently taking)

MEDICATION	DOSE	TIMES/DAY	MEDICATION	DOSE	TIMES/DAY

Do you use any natural/herbal or dietary supplements? YES NO

If yes – please explain _____

_____

EXERCISE YOU GET NOW

TYPE	MINUTES	SPEED/DISTANCE	DAYS/WEEK

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Cadillac Area YMCA Dillon Community Center

Senior Fit Participant
Information and Waiver Form

*** INDICATES REQUIRED INFORMATION**

***First Name_____ *Last Name _____**
*** Gender M or F *Date of Birth ____/___/____**

E-mail _____ cell phone _____

***Address _____**
***City _____*State _____*Zip _____**
***Home Phone _____**

Emergency Contact Person _____
Relationship_____ Phone _____

This statement must be signed by the participant or legal guardian.

I certify that I consent to participate in YMCA Programs. I further stipulate and agree to protect, indemnify, save, and hold harmless said Munson Hospital and Cadillac Area YMCA employees and volunteers against any and all claims arising out of my participation in YMCA Programs. I also certify that I have been screened medically and that there are no medical conditions or injuries that preclude my participation in YMCA Programs. I grant permission to Munson Healthcare Cadillac Hospital and Cadillac Area YMCA to share my personal health and medical information. I give my permission for photos and/or video to be taken and used for public relations purposes.

***Signed _____ Date _____**

Cadillac Area YMCA
9845 Campus Drive
Cadillac, MI 49601
Phone: 1(231)775-3369
Fax: 1(231)775-4309
www.cadillacareaymca.org

Senior Fit – Contract for Participation

We are excited about your participation in the Senior Fit program. As a participant, you are taking a big step in the management of your health, which requires a great deal of commitment on your part. Due to limited availability and outstanding interest in the program, your regular attendance is a must. Please read and initial each requirement listed below. If you need further clarification of any of these items, please bring those to the attention of your instructor.

I understand that exercise is a very important component to the management of my disease. I understand that my activities and progress will be reported to my doctor; therefore I am responsible for showing up to class 2 days per week. _____

I understand that regular attendance is required. If I am absent 4 consecutive days without notice and/or a reasonable excuse, Senior Fit staff will assume I am no longer interested and will fill my spot. I also understand that if my attendance becomes erratic without a reasonable excuse, I may be forced to forfeit my participation. ___

I understand that I am a participant on my own free will. I may terminate my participation in the program at any point in time. _____

I understand that my current health and fitness will be assessed at the beginning of the program and reassessed later in the program. I understand that my results will be shared with my physician and may be used to calculate clinical outcomes, for which I will remain anonymous. _____

Please sign below to verify that you have read and understand the information provided above.

_____ _____

Signature Date

_____

Please Print Name Clearly

Senior Fit

Participant Application for Payment Purposes Date:

We are required by law to keep information about you confidential. The information provided below will be used solely to assess your monetary contribution for participation in the program.

Name	Spouse
Employer	Employer
Permanent Address	Winter/ Other Address
City State Zip	City State Zip
Home Phone	Cell Phone

1. Household Gross ***Monthly*** Income

   Income #1 (example Social Security) $____

   Income #2 (example Retirement, alimony) $____

   Income #3 (include any other not listed above: taxable income, wages, tips, child support) $____

   Total: $____

If income is 0, please explain:

2. Number of Dependents in Family Unit Ages

CLIENT AFFIRMATION: I affirm that the statements made herein are true and correct to the best of my knowledge. I understand that any false or misstatements of material fact may result in my disqualification for a reduced enrollment fee. I understand that I may be asked to provide verification of income, expenses, dependents, bank statements, pay vouchers and tax statements. I understand that a credit report may be used as part of the contribution determination process.

Signature _____ Date_____

Staff Signature_____

Rev. 10/20