



# DUTCHESS COUNTY OFFICE FOR THE AGING (OFA)

## SENIOR EXERCISE PROGRAM APPLICATION

NAME:		CLASS LOCATION PREFERENCE:	
ADDRESS:	CITY:	ZIP:	
PHONE:		DATE OF BIRTH:	
EMAIL:			
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE:	
PRIMARY PHYSICIAN:		PRIMARY PHYSICIAN PHONE:	

Were you previously in an OFA exercise class?       Yes     No    If yes, when: \_\_\_\_\_

<u>Medical History</u>	YES	NO	<u>Medical History</u>	YES	NO
Polio Survivor	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis or Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Cataract surgery in the past six months	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Surgery in the past six months	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis (Rheumatoid or Osteoarthritis)	<input type="checkbox"/>	<input type="checkbox"/>	Stroke in the past six months	<input type="checkbox"/>	<input type="checkbox"/>
Fractured bone in the past six months	<input type="checkbox"/>	<input type="checkbox"/>	Lyme Disease	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss/dementia diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	Use cane or walker	<input type="checkbox"/>	<input type="checkbox"/>
Knee Operation– (date: _____)	<input type="checkbox"/>	<input type="checkbox"/>			
Hip Operation – (date: _____)	<input type="checkbox"/>	<input type="checkbox"/>			
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Under Control		

**Significant Health Events (past 3 months) - check all that apply**

<input type="checkbox"/> Chest pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Palpations during exertion <input type="checkbox"/> Tripping <input type="checkbox"/> Falling <input type="checkbox"/> Evaluation or treatment of a newly diagnosed condition under the care of a medical doctor, chiropractor, physical therapist or other doctor in the past 6 months.	<input type="checkbox"/> Painful joints <input type="checkbox"/> Muscle pain <input type="checkbox"/> Back pain <input type="checkbox"/> Dizziness
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Explain: \_\_\_\_\_

**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 Dutchess County Office for the Aging and the Landlord of this exercise facility 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.

\_\_\_\_\_  
*Participant's Signature*

\_\_\_\_\_  
*Date*

**Dutchess County - Senior Exercise Program**  
Demographic statistics for required New York State reporting

NAME:		TODAY'S DATE:
DATE OF BIRTH:	CLASS LOCATION:	

**How long have you been in the senior exercise program?**

- New / Less than 1 year   
  Between 2 & 4 years   
  More than 5 years   
  Return to Program

**Demographic information** (check all that apply):

- Low Income  
 Low Income Minority  
 Frail / Disabled (Defined Below)   
  No longer driving   
  Use cane / walker  
 Live Alone  
 Rural (Defined Below)

**Race / Ethnicity** (check one):

- American Indian / Alaskan Native  
 Asian  
 Black (Not Hispanic)  
 Native Hawaiian / Pacific Islander  
 Hispanic or Latino  
 White

**Definitions**

<b>LOW INCOME:</b>	<u>Household Size</u>	<u>Annual Household Income at or below</u>
	1 Person	- \$22,311 (\$1859 /month)
	2 Persons	- \$30,044 (\$2504 /month)
	3 Persons	- \$37,777 (\$3148 /month)

**FRAIL / DISABLED:** A person with one or more functional deficits in these areas:

- Physical functions
- Mental functions
- Activities of Daily Living (ADL) (eating, bed/chair transfer, dressing, toileting and continence)
- Instrumental Activities of Daily Living (IADL) (meal preparation, housekeeping, shopping, medications, telephone, travel and money management.)

**RURAL ZIP CODES:** If you live in any of these rural zip codes, please mark the appropriate box.

- |                                |                                |                                |                                |                                |
|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> 12501 | <input type="checkbox"/> 12522 | <input type="checkbox"/> 12564 | <input type="checkbox"/> 12574 | <input type="checkbox"/> 12585 |
| <input type="checkbox"/> 12504 | <input type="checkbox"/> 12531 | <input type="checkbox"/> 12567 | <input type="checkbox"/> 12578 | <input type="checkbox"/> 12592 |
| <input type="checkbox"/> 12506 | <input type="checkbox"/> 12538 | <input type="checkbox"/> 12569 | <input type="checkbox"/> 12580 | <input type="checkbox"/> 12594 |
| <input type="checkbox"/> 12507 | <input type="checkbox"/> 12540 | <input type="checkbox"/> 12570 | <input type="checkbox"/> 12581 |                                |
| <input type="checkbox"/> 12510 | <input type="checkbox"/> 12545 | <input type="checkbox"/> 12571 | <input type="checkbox"/> 12582 |                                |
| <input type="checkbox"/> 12514 | <input type="checkbox"/> 12546 | <input type="checkbox"/> 12572 | <input type="checkbox"/> 12583 |                                |

**DUTCHESS COUNTY - SENIOR EXERCISE PROGRAM**

**Doctor Consent Form**

Participant Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
*Please print*

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Dear Dr. \_\_\_\_\_,  
*Print physician's name*

Your patient, (*name*) \_\_\_\_\_ has requested enrollment in an exercise program designed to reduce injury, improve balance, mobility and muscle strength for older adults participating in this program. It is based on an Osteoporosis Prevention Program developed at Tufts University by Miriam Nelson, Ph.D.

The class meets twice a week for one hour and the exercises consist of:

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

Ankle cuffs with removable pellets and one-pound hand weights allow for individualizing the exercises for each participant and tailoring their progression with their comfort level. Your approval is required before participation can begin. In the event of withdrawal from the program for medical reasons or any extended period of time, your consent, again, be required before resuming exercises.

Please return this form to the patient, or to the Dutchess County Office for the Aging. If you have any questions, please call the exercise coordinator, Judy Hearney at (845) 831-0512.

I give consent for (*patient name*) \_\_\_\_\_ to participate in a supervised progressive weight training program.

Comments/restrictions: \_\_\_\_\_

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\_\_\_\_\_  
*Physicians's Name (please print)*

\_\_\_\_\_  
*Physician's Phone Number & Fax*

\_\_\_\_\_  
*Physician's Signature*

\_\_\_\_\_  
*Date*