MARCUS J. MOLINARO
COUNTY EXECUTIVE

TODD N TANCREDI
DIRECTOR

COUNTY OF DUTCHESS

OFFICE FOR THE AGING

Calendar year 2021

Dear Exercise Participant:

The Dutchess County Office for the Aging is pleased to bring you the Senior Exercise Program, we are currently in the 21st year of this program in operation.

The Senior Exercise Program is partially funded by the New York State Office for the Aging, which requires that all participants be given the opportunity to make a confidential, voluntary donation toward the cost of the service. The contribution level that we would like to **suggest is $25 per year**. This is approximately **24 cents per class** if you participate twice per week. The funds received from these donations will be used to offset the administration of this program such as program coordination, leader training, mailings, copies and educational material.

This is a suggested donation only, and a decision not to contribute, or the inability to contribute, will in no way impact the level of service you receive. The amount of your contribution will remain confidential.

Donations may be mailed to the Dutchess County Office for the Aging, 114 Delafield Street, Poughkeepsie, NY 12601. Checks should be made payable to **Dutchess County Office for the Aging**, with 'exercise' in the memo and on the envelope. A receipt of your contribution will be provided to you at your request.

If you have already made a contribution for this year, thank you, your continued support is appreciated. If you have any questions concerning this program, please contact the Office for the Aging at 486-2555.

Sincerely,

Todd N. Tancredi, Director

114 Delafield Street, Poughkeepsie, New York 12601 • (845) 486-2555
Aging Fax (845) 486-2571 • NY Connects Fax (845) 486-2599
www.dutchessny.gov

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: _____

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

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

☐ Chest pain
☐ Shortness of breath
☐ Palpations during exertion
☐ Tripping
☐ Falling
☐ Painful joints
☐ Muscle pain
☐ Back pain
☐ Dizziness
☐ 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.

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

LOW INCOME:

Household Size	Annual Household Income at or below
1 Person	- $19,320 ($1,610 /month)
2 Persons	- $26,130 ($2,177 /month)
3 Persons	- $32,940 ($2,745 /month)

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

1. Physical functions
2. Mental functions
3. Activities of Daily Living (ADL) (eating, bed/chair transfer, dressing, toileting and continence)
4. 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.

☐ 12501	☐ 12522	☐ 12564	☐ 12574	☐ 12585
☐ 12504	☐ 12531	☐ 12567	☐ 12578	☐ 12592
☐ 12506	☐ 12538	☐ 12569	☐ 12580	☐ 12594
☐ 12507	☐ 12540	☐ 12570	☐ 12581	
☐ 12510	☐ 12545	☐ 12571	☐ 12582	
☐ 12514	☐ 12546	☐ 12572	☐ 12583	

DUTCHESS COUNTY - SENIOR EXERCISE PROGRAM

Doctor Consent Form

Participant Name: _____ Phone: _____
Please print

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. You 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: _____

_____

_____ _____
Physicians's Name (please print) *Physician's Phone Number & Fax*

_____ _____
Physician's Signature *Date*