312 Marlboro Street, Keene, NH 03431
603-352-2253 800-541-4145
Fax: 603-358-3904

Age in Motion

Participant Letter

Dear Participant:

Thank you for your interest in Age in Motion, a strength, balance, and flexibility exercise program for older adults. A list of locations, days and times is included in this packet. The program generally meets twice a week. A $2.00 donation per class is requested but not required for participation.

This Age in Motion packet contains forms to be completed by both you and your physician prior to starting the program and must be updated annually thereafter.

Forms to be given to your physician:

- **Physician Information Letter** - Please fill in the date, your doctor's name, and your name before giving to your physician.
- **Medical Clearance for Exercise** - Fill out Participant section.

Forms to be completed by you and returned to the program instructor:

- **Informed Consent**
- **Participant Information**

If you have any questions or would like further information about the Age in Motion Program, please contact HCS at 603-352-2253 or info@hcsservices.org.

Sincerely,

Laura Brow, RN
Director of Clinical Programs

312 Marlboro Street, Keene, NH 03431
603-352-2253 800-541-4145
Fax: 603-358-3904

Age in Motion

Physician Information Letter

Date: ___________________

Dear Doctor _________________________:

Your patient, ______________________________, is interested in participating in *Age in Motion*, a strength, balance and flexibility exercise program for older adults which generally meets twice a week. *Age in Motion* is based on the principles of the Strong Living Program developed by researchers and exercise physiologists at Tufts University.

Prior to participating in *Age in Motion* your patient is required to receive medical clearance for exercise. Attached is the Medical Clearance for Exercise form which we ask that you complete and return to the Wellness Department at HCS. You may return this form by using the attached self-addressed envelope or by faxing it to 603-358-3904.

If you have any questions or would like to discuss your patient's participation in this program, please contact me at 603-352-2253.

Sincerely,

Laura Brow, RN
Director of Clinical Programs

Home Healthcare Hospice & Community Services
HCS services.org

Home Healthcare, Hospice and Community Services, Inc.
312 Marlboro Street, Keene, NH 03431
603-352-2253 800-541-4145
Fax: 603-358-3904

Please Check One:

☐ New Participant

☐ Annual Update

☐ After Illness/Injury

Age In Motion

Medical Clearance for Exercise

Participant Completes:

Participant Name: ______________________________ Date of Birth: ______________

Street Address: ______________________________ City: ______________

State: ______________ Zip Code: ______________ Phone #: ______________

Location of AIM Program: ______________________________

- **I give permission for my physician to share information about my health status for exercise with HCS.**

Participants Signature: ______________________________ Date: ______________

Physician Completes:

Please check the appropriate answer:

☐ **YES,** my patient can participate in the Age In Motion Program **without restriction.**

☐ **YES,** my patient can participate in the Age In Motion Program, **but with the following restrictions:**

____

☐ **NO,** my patient cannot participate in the Age In Motion Program.

Physician's Signature: ______________________________ Date: ______________

Print Physician's Name: ______________________________

Address: ______________________________

Phone Number: ______________________________ Fax Number: ______________

Physician Directions: Please complete Medical Clearance Form and return either by mail or fax to 603-358-3904 Attn: AIM Program
Thank You.

Age in Motion Program
Informed Consent

I declare that I have voluntarily enrolled in the Age In Motion Program of progressive exercise; a program designed to place a gradually increased workload on the heart, lungs, muscles and bones to help improve their function. I assume full responsibility during and after my participation in this program, for my choices to use or apply, at my own risk, any portion of the information or instruction I receive. I understand that participation in such a program may be associated with some risks and that I willingly accept these risks. These risks may include but are not limited to: muscle soreness, fainting, disorders of heart beat, abnormal blood pressure and heart attack. I assume all risks and responsibility for any injury, damage or any other adverse event that may result from my participation in this program.

I understand that I may stop or delay my participation in the program if I so desire and that I may be requested to stop and rest by an instructor who observes any symptoms of distress or abnormal response. I understand that each person may react differently to the program exercises and that it is my responsibility to inform the program leader or my healthcare provider if I experience any unusual symptoms.

I understand I need to have obtained medical clearance from my physician and my physician must return a completed Medical Clearance for Exercise form to HCS before I may begin this program. In addition this form must be completed on an annual basis and following any illness or injury that has affected my health and well-being.

In consideration of being allowed to participate in this program, I do hereby waive and release the Age In Motion Program and Home Healthcare, Hospice and Community Services, Inc. 312 Marlboro Street, Keene, NH 03431 and their officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liability for injuries resulting from my participation in the program. I do hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury to myself, including those caused by the negligent act or omission of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in the program.

I declare that I have read, understood and agree to the contents of this informed consent agreement in its entirety.

Signature:____ **Date:** ___________________

Printed Name: ____

Witness: ____ **Date:** ___________________

Printed Name: ____

AGE IN MOTION

Participant Information

Participant Name: ____

Street Address: ____

City: ____________________ State: ____________________ Zip Code: ____________________

____

Phone Number: ____

In case of emergency, please call:

Name: ______________________________ **Phone Number:** ____________________

Relationship: ____

Name of Physician: ______________________________ **Phone Number:** ________________

____

To be completed by Instructor:

Program Site: ______________________________ Start Date: ________________________

Program Leader: ____