REGISTRATION FORM

"GET MOVING, GET ACTIVE"

Fitness program for Parkinson's patients (circle one): Session II • Session III • Session IV

Name: ____

Address: ____

Phone: ____

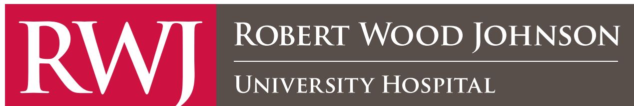
Email: ____

Amount enclosed: ___________________________

Make checks payable to: "NJ Chapter APDA"

We must receive a signed copy of the consent form on the back of this registration page.
You and your doctor must sign the form and mail it back prior to your sessions.

Please mail your registration, consent form and payment to:
NJ APDA Parkinson I &R Center
120 Albany Street
New Brunswick, NJ 08901



PARKINSON FITNESS PROGRAM INFORMED CONSENT

Participant: ______________________________________ Date: _______________________________

Address/Zip and Phone: ____ (   ) __________________

I have voluntarily agreed to engage in a supervised Parkinson Fitness Program. My participation has been recommended and approved by my physician, Dr. ___________________________________ .

1. The program has been explained to me, and I understand that a therapist(s) will be monitoring my tolerance to the fitness activities and my ability to continue participating. I authorize RWJUH therapists, or their designees, and other personnel to terminate, modify or if in the judgement of the therapist or his/her designee to address my participation in the program.

2. If unforeseen conditions do occur during any of the fitness sessions, I authorize the therapist(s) to call the paramedics on my behalf, and would like the following person contacted:

Name: ____ Phone: _____________________________

Relationship: ____

3. I understand information obtained during this program will be kept confidential and will not be released without my authorization. However, I do give permission for the information to be used for statistical or scientific purposes with my right of privacy retained.

4. I have the right to withdraw from this fitness program at any time. (The class fee for the unused sessions will not be reimbursed to me).

I acknowledge that no guarantees have been made to me concerning the results of my participation in the program at RWJUH.

I have read the above and fully understand the above statements. I have been provided with the opportunity to ask questions.

Participant: ______________________________________ Date: _______________________________

Physician Certification:
All participants must meet the following criteria:

- Must be able to comprehend and follow directions and maintain attention for one hour.
- Must be able to arrive at the location of the class indecently or with assistance from a care partner.
- In order to participate in the standing activities of the program, must be able to ambulate a distance of at least 75 feet with or without a cane or walker.

Physician: ______________________________________ Date: _______________________________

Physician's Address and Phone: ____ (   ) __________________

If you have any questions related to this program, please contact Elizabeth Schaaf at the
NJ American Parkinson Disease Association Information and Referral Center at 732-745-7520.
Consent in effect for 6 months from date of signature by patient and physician.
PLEASE RETURN THIS FORM BEFORE THE BEGINNING OF THE PROGRAM TO:
NJ APDA 120 Albany St., Ste 360 New Brunswick NJ 08901, or fax to 732-745-3114. Thank you.