# Arthritis Foundation's Exercise Program

The Healthy Lifestyles Fitness Center
200 Chesapeake Blvd., Suite 2500
Elkton, MD 21921
410-620-3101 / fax 410-620-3606

## STEP 1: Application Form

Name _____ Home Phone: _____

Address: _____ Business: _____

City: _____ State: _____ Zip: _____

There are potential risks with any exercise program and I understand and agree that the Arthritis Foundation and the Healthy Lifestyles Fitness Center/Cecil County Government will not have or assume any financial responsibility for medical expenses or compensation for any injury I may suffer during or resulting from participation in this program. I do hereby, for, myself my heirs, executors and administrators, waive, release and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in this or any future programs.

I also give my permission to _____ to complete a physician consent form. *(Name of Physician)*

_____ _____
*Signature of Applicant* *Date*

## STEP 2: Activity Survey

Which description best fits you? (Check only one)

☐ I have a lot of joint limitations or many joints affected by arthritis and I am not very physically active.

☐ I only have minor joint problems but have weak muscles or get tired easily. I have been doing some exercise or physical activity. I can get down and up from the floor without help.

**STEP 3: Physician Information** (*To be completed by your physician*)

Patient's name: _____

Diagnosis (type of arthritis) _____

Contraindications/precautions (why the patient should avoid or limit participation):
_____

_____

_____

Which level of the program would be most appropriate? (Check one)

☐ BASIC (for those with severe to moderate or multiple joint involvement who are sedentary or who have limited exercise experience.)

☐ ADVANCED (for those with minimal joint involvement whose primary problem is lack of endurance, and who can get down and up from the floor without assistance).

_____ _____

*Signature of Physician* *Date*

_____ _____

*Physician's name printed* *Physician's phone number*