ACTIVE LIVING PROGRAM

GENERAL INFORMATION

Program Schedule:

<table>
<thead>
<tr>
<th>Tuesdays</th>
<th>Thursdays</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:00 p.m. – 3:00 p.m.</td>
<td>8:30 a.m. – 9:30 a.m.</td>
</tr>
<tr>
<td>3:00 p.m. – 4:00 p.m.</td>
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</tbody>
</table>

* The day of your class will depend on your preference and space availability
* Dates are subject to change due to changes in the hospital schedule, and or other unforeseen

Program Description:

The program is an 8 week generalized exercise class focused on improving balance, strength, flexibility and conditioning. For one hour each week, participants will exercise and target muscles and joints in the legs, arms and core. Exercises, although very effective, are simple enough for you to repeat at home. Participants need to be highly independent, be able to follow instructions and be medically and cognitively safe to participate in a group based exercise class.

Fees Schedule:

- $100 per session. Each session includes 8 classes.
- There are no refunds or make-up times for missed classes.
- You may only attend class for your scheduled days.
- The fee includes all exercise classes.
- Payments can be made in person at the Patient Accounts Department (located on the first floor) or by cheque payable to St. John’s Rehab.
- Please forward all completed forms and fees to:

Sunnybrook St. John’s Rehab
Outpatient Services
285 Cummer Ave.
Toronto, ON, M2M 2G1

Acceptance to the program is subject to:

1. Review all of the completed forms
2. Receipt of payment

Please bring a towel, bottle of water and wear comfortable clothes and running shoes. If you have any question, please feel free to contact us at: 416-226-6780 ext. 7215
ACTIVE LIVING PROGRAM

PARTICIPANT APPLICATION FORM

Name: __________________________ Date of Birth: ______ Date: ______

Address: ___________________________________________________________

Home Phone: __________________________ Alternate Phone: ______

Emergency Contact Name: __________________________

Emergency Contact Phone: __________________________

Please answer the following questions as they will determine which class is most appropriate for you.

Please indicate which sessions you would prefer:

1st Choice: __________________________
2nd Choice: __________________________
3rd Choice: __________________________

How did you become aware of this program? __________________________

Please indicate if you have experienced any of the following conditions:

<table>
<thead>
<tr>
<th>Condition</th>
<th>With a cane</th>
<th>With a walker</th>
<th>Without any walking aids</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you able to walk independently</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Are you able to walk up and down stairs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. To stand up from a seated position?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How often do you currently exercise (please circle)?

Less than 1x/week; 1 – 2x/week; 2 – 3x/week; 3 – 4x/week; More than 5x/week

What type of exercise(s) do you do? __________________________

______________________________________________________________

When you exercise, do you experience any of the following?

If applicable, please explain

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortness of Breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest Pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have a caregiver who will be assisting in the Active Living Program? __No __Yes
ACTIVE LIVING PROGRAM

1. If my application for the Active Living Program is accepted, I understand and agree that St. John’s Rehab will not assume financial responsibility for any medical expense or compensation for any injury I may suffer either during or resulting from participation in this program.

2. I understand that eligibility into the program is determined once all submitted forms are reviewed.

3. I understand that I am responsible for reporting any changes in medical and/or functional status as it may affect my ability to safely participate in the program.

Name: (Please print) __________________________________________________________

                   Last                           First

Signature: ________________________________________________________________

Witness: _________________________________________________________________

Date Signed: ______________________________________________________________
ACTIVE LIVING PROGRAM

PHYSICIAN’S SCREENING FORM

Participants Name: _________________________________________________________________

The Active Living Program includes 60 minutes of gentle exercises in a group-based setting to help improve range of motion, muscle strength, endurance and balance. Exercise intensity ranges from no resistance to light resistance depending on the patient’s ability. Exercises are done in sitting or standing with support. This class is suitable for people who are independently mobile, are medically and cognitively stable and are able to follow instructions and do not focus on any specific impairment or condition.

Please indicate if the participant has any of the following conditions/impairments to help us determine their suitability for the program? Please inform us if any of these conditions are medically stabilized as well.

If applicable, please explain

Heart Condition    ___No   ___Yes  ________________________________________
Respiratory Condition  ___No   ___Yes  ________________________________________
Epileptic Seizures  ___No   ___Yes  ________________________________________
High or Low Blood Pressure ___No   ___Yes  ________________________________________
Diabetes    ___No   ___Yes  ________________________________________
Fainting Spells   ___No   ___Yes  ________________________________________
Incontinence Issues  ___No   ___Yes  ________________________________________
Deafness   ___No   ___Yes  ________________________________________
Limited Vision   ___No   ___Yes  ________________________________________
Poor Balance     ___No   ___Yes  ________________________________________

Are there any other medical conditions or symptoms that may affect participation in a group based exercise class?
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

☐ In my opinion, this participant is medically stable and safe to participate in the Sunnybrook St. John’s Rehab’s Active Living Program.

ADDITIONAL COMMENTS:
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Physician’s Name: _________________________________  Physician’s Signature: _________________________________

Phone: _________________________________  Date: _________________________________

For more information or questions please contact us at 416-226-6780 x 6949