Supportive Living, INC.
BRAIN INJURY PROGRAMS

7 Oakland St.
Lexington, MA 02420
(781) 274-8711
www.supportivelivinginc.org

SLI Brain Injury Wellness Center: Exercise Program Registration

Date Completed: _____ Completed by: _____

Participant Information		
Participant Name:	Date of Birth:	Gender:
Home Street Address:	Town:	State:
Emergency Contact Information		
Name:	Phone:	Relationship:

Participant Billing Information

Does the participant agree to pay a fee of $10 per 1-hour session?* ☐ Yes ☐ No

*Note: Fee may be negotiated on a sliding scale for those in need. Please reach out to the Brain Injury Wellness Center manager.

Please indicate the agreed amount to be paid per session, if not $10: _____

Does the participant manage his/her own finances? ☐ Yes ☐ No

If no, name of representative payee: _____

Email: _____ Phone: _____

Billing Address (If different than home address):

_____

Street Address Town State ZIP

Please indicate with your signature below that you, the participant, agree to the above information regarding billing for the SLI Brain Injury Wellness Center exercise program.

Signature

_____ Date: _____

Please complete next page

SLI Brain Injury Wellness Center: Health Information for Exercise Program

Participant Health Information	
Type of Brain Injury (if applicable):	Date of Injury:
Other Relevant Diagnoses (if applicable):	Allergies:
Current Medications:	Resting Heart Rate and Blood Pressure: HR: BP:
Height:	Weight:

1) Do you have a pacemaker/cardiac defibrillator? ☐ YES ☐ NO

   If yes, indicate type of implant _____

2) Have you had heart surgery before? ☐ YES ☐ NO

   If yes, indicate type of surgery _____

3) Are you restricted from performing certain tasks/activities? ☐ YES ☐ NO

   If yes, indicate restricted activity/task(s) _____

4) Are you currently taking medications for a chronic medical condition? ☐ YES ☐ NO

   If yes, what is the name of medication? _____

5) Type of assistive device used for walking (if applicable):

   ☐ Quad cane ☐ Standard crook cane ☐ Gait belt with assist ☐ Crutches ☐ Standard walker

   ☐ Rolling walker ☐ Wheelchair

6) Do you require assistance with any of the following? (check all that apply):

   ☐ Transfer: Bed to chair ☐ Transfer: Chair to Chair ☐ Laying down to Standing ☐ Bathroom

   If yes, indicate level of assistance needed:

   ☐ One person assist ☐ Two person assist ☐ Assistive Device (indicate) _____

7) Do you have a history of frequent falls? ☐ Yes ☐ No

   If yes, when was your last fall? _____

8) Do you have a history of seizures or seizure disorder? ☐ Yes ☐ No

Please use this space to make any other comments regarding the participants ability to exercise safely:

_____

_____

_____

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Physician Consent for SLI Brain Injury Wellness Center Exercise Program

Your patient, _____ D.O.B: _____, has expressed interest in participating in the Supportive Living, Inc. Brain Injury Wellness Center Exercise Program held at Douglas House in Lexington, MA. The Exercise Program is designed to promote an overall healthier lifestyle, improve mobility, promote therapeutic exercise and support independence. A comprehensive medical and activity questionnaire will be completed, followed by a complete fitness assessment. Participants will be instructed and supervised during all exercises. Exercises will include cardiovascular, resistance, flexibility, and balance training. The exercises and intensity of the program will be modified to fit each individual patient's needs, and health goals.

Please list any modifications, comments, or concerns you may have for testing and exercise:

_____

_____

_____

If your patient requires HR or other parameters monitored during exercise, please specify:

_____

_____

Please indicate with your signature below that your patient is medically cleared to participate in the fitness program.

Physician Name: _____ Date: _____

Physician Signature: _____ Date: _____

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SLI Brain Injury Wellness Center: Release and waiver for Participants, Interns, and Volunteers

In consideration of the undersigned being on premise of voluntarily participating in the independent program at the SLI Wellness Center (SLIWC), the undersigned, individually and on behalf of their undersigned heirs, representatives and next of kin, agrees to:

1. release, waive and discharge, and to indemnify and hold harmless SLIWC and its employees, volunteers and affiliates from all loss, expense and liability for injury, death and damages to the person or property of the undersigned, whether caused by the negligence of SLIWC , its employees, volunteers, or affiliates, or otherwise while using SLIWC facilities; and
2. assume full responsibility for risk of injury, death of damages to the person or property of the undersigned, whether caused by negligence of SLIWC, or its employees, volunteers or affiliates or otherwise while using SLIWC facilities.

I understand the program is not a therapy program, nor a substitute for medical treatment. I do represent and warrant that I have been advised to seek consultation from a doctor about whether I can safely participate in this program and whether there are precautions or limitations to my participation.

The facility reserves the right to limit participation of individuals when criteria are not met or the safety of participants or staff is compromised.

The undersigned acknowledges that no oral or written statements or agreements contrary to this document have been made to the undersigned and that this document supersedes any and all prior statements and agreements with SLIWC. This document may only be changed in a writing executed by SLIWC.

The agreements in the document shall be continuing and shall not terminate without the prior consent of SLIWC.

The undersigned has read, understands and voluntarily signs this document.

Print Name _____ Date _____

Signature _____

Media/Photo Waiver

I authorize Supportive Living, Inc. to publish photographs, recordings, or videotapes in which I appear to be used for public view. Media use could include, but is not limited to: television, newspapers, internet, advertisements, and other medium.

Signature

_____