Supportive Living, INC.
BRAIN INJURY PROGRAMS

Neuro Wellness Center
7 Oakland St.
Lexington, MA 02420
(781) 274-8711 | Fax: (781) 937-5503

# SLI Neuro Wellness Program: Boxing for Balance, Core and More & Yo-Abilities: Chair Yoga Class Registration

Thank you for registering for the Supportive Living, Inc. (SLI) Boxing for Balance, Core and More class for people living with neurological disorders and acquired brain injury. Please complete the following registration form to give us an idea of your current health status and fitness-related goals. You will also find a physician's consent form and a waiver attached. Please ensure all paperwork is completed and submitted to the Neuro Wellness Program manager before beginning the program. Paperwork may be submitted by email or by fax to (781) 937-5503.

If you have any questions, please reach out to Kara Lavertu, Neuro Wellness Program manager, at klavertu@supportivelivinginc.org or call at (781) 274-8711.

## Participant Information

**Participant Name:** _____

**Date of Birth:** _____ **Gender:** _____

**Address:** _____

Street Town State ZIP

**Home Phone:** _____ **Cell Phone**: _____

**Email:** _____

## Emergency Contact Information

**Contact Name:** _____

**Home Phone:** _____ **Cell Phone:** _____ **Email**: _____

**Relationship to Participant**: _____

**How did you learn about this program?** _____

Which class are you interested in signing up for?

- ☐ Boxing for Balance
- ☐ Chair Yoga

*Please complete next page*

| Participant Health Information | |
|---|---|
| Type of neurological disorder or ABI (if applicable): | Date of Injury: |
| Other Relevant Diagnoses (if applicable): | Allergies: |
| Current Medications: | Resting Heart Rate and Blood Pressure:<br>HR: BP: Date: |
| Height: | Weight: Date: |

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 date and type of surgery _____
3) Are you restricted from performing certain physical tasks/activities? ☐ Yes ☐ No
   If yes, indicate restricted activity/task(s) _____
4) Do you have any significant vision, hearing or communication challenges?
   If yes, please indicate: _____
5) Type of assistive device used for mobility (if applicable):
   ☐ Cane ☐ Crutches ☐ Standard walker ☐ Rolling walker ☐ Manual Wheelchair ☐ Motorized 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*
   *Please note that if you need assistance with using the bathroom, you must have a PCA with you to do so
   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 a seizure disorder? ☐ Yes ☐ No
   If yes, and you have a specified protocol to follow in the event of seizure, please provide that
9) Do you have a chronic respiratory disease such as asthma, COPD or chronic bronchitis? ☐ Yes ☐ No
   If yes, please indicate diagnosis: _____
10) Do you have a Do Not Resuscitate (DNR) order in place? ☐ Yes ☐ No
11) Have you been hospitalized within the last 6 months? If yes, please explain:
   _____
12) Do you experience any cognitive challenges, such as short-term memory issues or aphasia? Please explain:
   _____

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

_____

_____

What are your goals for this exercise program? Consider stamina, strength, balance, range of motion, etc.

_____

_____

Supportive Living, INC.
BRAIN INJURY PROGRAMS

Neuro Wellness Center
7 Oakland St.
Lexington, MA 02420
(781) 274-8711 | Fax: (781) 937-5503

**Physician Consent for SLI Neuro Wellness Program Boxing Class**

Your patient, _____ D.O.B: _____, has expressed interest in participating in the Supportive Living, Inc. Neuro Wellness Program: Boxing for Balance, Core and More class. This fitness boxing class is designed to promote an overall healthier lifestyle, improve mobility, promote therapeutic exercise and support independence for individuals recovering from brain injury and other neurological disorders. Participants will be instructed and supervised during all exercises. Exercises will include cardiovascular, resistance, flexibility, strength and balance training. The exercises and intensity of the program will be modified to fit individual needs and health goals. All physical contact is with punching bags and participants will be provided boxing gloves and instructed on proper form.

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 by signing below that your patient is medically clear to participate in the fitness program.

Physician Name: _____ Date: _____

Physician Signature: _____ Date: _____

Supportive Living, INC.
BRAIN INJURY PROGRAMS

Neuro Wellness Center
7 Oakland St.
Lexington, MA 02420
(781) 274-8711 | Fax: (781) 937-5503

SLI Neuro 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 or 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**

_____