Town of Chatham

Council on Aging
193 Stony Hill Road
Chatham, MA 02633

Mandi Speakman
Director
aspeakman@chatham-ma.gov

Tel: (508) 945-5190
Fax: (508) 945-5198
www.chathamcoa.com

August 15, 2016

Dear Physician,

Your patient is requesting your approval for their participation in the **FIT, FUN & FALL FREE** exercise program. This class will offer a combination of strength, flexibility and balance exercises provided by the Chatham Council on Aging and the Visiting Nurses Association of Cape Cod.

PHYSICIAN'S CLEARANCE is REQUIRED prior to beginning participation in this program.

Your patient will need to be able to participate in the following:

- Warm up-stretching, marching in place
- Strength & Range of Motion-sitting with weights or therabands
- Strength & Range of Motion-standing
- Balance Exercises-progressive as participants improve
- Fun-simple dance steps
- Cool down

WHEN:

- Tuesdays & Thursdays, 9:30am-10:30 am
- 6 week session: 1st session runs Sept. 20th - Oct. 27th, 2016

Should you have any questions or require clarification on the parameters of this program please don't hesitate to call me at 508-945-5190.

Thank you,

Mandi Speakman
Director

VISITING NURSE ASSOCIATION
OF CAPE COD
Member Cape Cod Healthcare

Fit, Fun and Fall Free
Physicians Approval Form

Participant Section:

I, _____, understand that I will be participating in one of the following VNA of Cape Cod's Programs and will, to the best of my ability, attend every session of the program. I am also responsible to inform the staff of my health status each session. If symptoms of distress, chest pain or other ailments are present, I understand that I will not be able to participate that given day. In addition, I hereby release Cape Cod Healthcare, its affiliates, and employees from any liability whatsoever occasioned by my participation in the program.

SIGNED: _____ DATE: _____

PRINT NAME: _____ PHONE: ( ) _____

ADDRESS: _____ D.O.B. _____

CITY,STATE,ZIP: _____

EMERG CONTACT: _____ PHONE: ( ) _____

RELATIONSHIP: _____ PHONE: ( ) _____

Physician Section:

The above patient may participate in the above VNA of Cape Cod's program, based on the most recent medical information at my disposal.

SIGNED: _____ DATE: _____
(Primary Care Physician)

PRINTED: _____

* Physician's signature will need to be renewed annually.

NOTE: This form may be faxed

Offered by the VNA in collaboration with the Chatham Council on Aging, 193 Stony Hill Road, Chatham MA 02633
Please return to the Chatham COA: Fax 508-945-5198. Call with questions 508-945-5190.