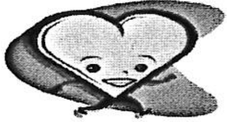

Walking Program

A Community Program of Cape Cod Healthcare and its affiliate, The Visiting Nurse Assoc of Cape Cod

Physicians Approval Form

Participant Section:

I, ______________________________, understand that I will be participating in the VNA of Cape Cod's walking Program 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, including, but not limited to, my participation in field trips.

SIGNED: ______________________________ DATE: ____________________

PRINT NAME: ______________________________ PHONE: ( ) ____________________

ADDRESS: ______________________________ D.O.B. ____________________

____

EMERG CONTACT: ______________________________ PHONE: ( ) ____________________

RELATIONSHIP: ______________________________ PHONE: ( ) ____________________

Physician Section:

The above patient may participate in the walking 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

VNA of Cape Cod ~ 434 Route 134, Suite G-1, South Dennis, MA 02660
Phone toll free: 1-800-631-3900 x 7423 or direct 508-957-7423 FAX: 508-394-2109