Activity Readiness Assessment

Please read and consider the following list of conditions. To protect your privacy, please DO NOT WRITE anything next to them:

- Chest pains while at rest and/or during exertion
- Previous heart attack
- High blood pressure
- Diabetes
- Frequent fast, irregular heartbeats OR very slow heartbeats
- Previous hip or spinal fracture (as an adult)
- Shortness of breath after mild exertion, at rest, or in bed
- Open cuts on your feet that do not seem to heal
- An unexplained weight loss of ten (10) pounds or more in the past six (6) months
- Any heart or circulatory conditions, such as vascular disease, stroke, chest pain, congestive heart failure, poor circulation to the legs, valvular heart disease, blood clots
- Lung disease
- More than two falls in the past year (no matter what the reason)
- More than one year since you have engaged in regular physical activity

1. Is your physician unaware of any of the above conditions?

Check One ☐ Yes ☐ No

2. Has your physician recommended any limitations to your physical activity?

Check One ☐ Yes ☐ No

Please sign that you understand the above questions and have completed this assessment. Ask your Program Advisor if you have any questions or concerns.

Name (Please print): _____

Signature: _____ Today's date: _____

Note:
You may be asked to obtain a signed Release for Activity or a note from your health care provider allowing you to participate before starting the program. If you are not asked to obtain a release, you are cleared to begin a gradual program of regular exercise.

Physical Activity Waiver

I acknowledge that I have voluntarily chosen to participate in a program of progressive physical exercise. I acknowledge that the strenuous nature of the program and the risks associated with my participation in the program have been explained to me, including, but not limited to, risks of physical injury, abnormal blood pressure, heart attack and death; and risks associated with the negligence of a Healthways participating location and any other organization participating or involved in providing or promoting any classes, functions, programs, testing, or other activities that I participate in at a Healthways location (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing).

By signing this document, I expressly assume all risk for my health and well-being and expressly assume the other risks associated with participating in the program, including, but not limited to, the negligence of a Healthways participating location and any other organization participating or involved in providing or promoting any classes, functions, programs, testing, or other activities that I participate in at a participating location (including without limitation the owners, officers, directors, employees, and representatives of the foregoing). I also hereby release, waive, discharge and covenant not to sue a class instructor, a Healthways participating location, any sponsoring organization, Healthways, Inc., or any of its subsidiaries or any other organization providing or promoting classes, functions, programs, testing, or other activities that I participated in at a Healthways location (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing) at any time hereafter, from any and all demands, liabilities, losses, or damages (including death or damage to property) caused or alleged to be caused in whole or in part by the negligence of any of the foregoing people or entities.

I have read, understand, had explained to me, and had the opportunity to ask questions concerning this waiver, release, and express assumption of risk. I have also read, understand, and will adhere to all guidelines and policies in regard to this benefit. This waiver and release shall survive the term of any agreement with a Healthways participating location.

Print Member's Name

Member's Signature | Date

Emergency Contact Name | Contact Phone Number

Participating Location Name and Staff Signature | Date

Release for Activity

(Member's Name) _____ wishes to participate in exercise and/or fitness activities and has been referred to a physician for an activity release.

Healthways offers physical activity benefits to member groups through fitness center networks in your area. The member may use amenities such as exercise equipment, swimming pools and may also participate in strength and conditioning classes designed for older adults which can be completed from a seated position.

Specific comments regarding limitations or contraindications for activity:

Physician or Licensed Practitioner Signature

Date

You may mail or fax this completed form to the participating location, Attn: Program Advisor.

For Site Use Only

1425 - Rockwell Collins Recreation Center
400 Collins Rd. N.E. M.S. 154-100
Cedar Rapids, IA 52498
Phone: (319) 295-2552
Fax: (319) 295-8833

Staff Signature

HEALTHWAYS

Incident Report

Please complete this form for all incidents involving Program Members and report to your Program Advisor immediately. Please print all information.

Participating Location Representative Completing Form:		**Today's Date:**
Participating Location:	1425 - Rockwell Collins Recreation Center 400 Collins Rd. N.E. M.S. 154-100 Cedar Rapids, IA 52498 Phone: (319) 295-2552 Fax: (319) 295-8833	

Member Information:

Name:	
Address:	
Home Phone:	
Health Plan:	Member ID:

Description of Incident:

Date(s):
Time(s):
Witness:
Description of Incident:

For Healthways Internal Use Only:

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HEALTHWAYS

Healthways SilverSneakers Fitness Program

Promotion Code							

Guest Pass Form

1425 - Rockwell Collins Recreation Center

Welcome to SilverSneakers® Fitness Program! If you are Medicare-eligible or a group retiree member, we invite you to enjoy any of the amenities offered here as part of SilverSneakers. Please fill out the information requested below along with the physical activity waiver and emergency contact information before beginning your physical activity. If you need assistance, feel free to ask the Program Advisor.

This Guest Pass is sponsored by SilverSneakers. By completing this form, I agree for my information to be shared with SilverSneakers. In addition, I agree that my information may be shared with Medicare Advantage health plans, and I may be contacted by health plans through direct mail at the address I submit below.

Health Plan / Insurance Company Name

Today's Date

Month / Day / Year

Last Name **First Name** **MI**

Address

City **State** **Zip Code**

Telephone **Gender** **Date of Birth**

Area Code - - M/F Month / Day / Year

Confidential

Confidential

HEALTHWAYS

Exercise Your Opinion

Dear Member,

Our number one goal is to provide you a great fitness program. We want you to enjoy your visits and feel comfortable with the participating location staff, equipment and classes. Please share your comments and/or suggestions about how we can improve your experience.

I am a current member of:

- ☐ SilverSneakers
- ☐ Prime

I am:

- ☐ very satisfied
- ☐ somewhat satisfied
- ☐ neither satisfied nor dissatisfied
- ☐ somewhat dissatisfied
- ☐ very dissatisfied

Please tell us why: _____

_____

_____

How has this program improved your health: _____

_____

_____

Please print.

Member name: _____ Date: _____

Address: _____

City: _____ Phone: _____

E-mail address: _____

Participating location name: 1425 - Rockwell Collins Recreation Center

Sponsoring health plan /organization: _____

By signing this sheet, I give permission for Healthways to use my comments and to be contacted directly regarding my testimonial via the contact information I have given.

_____

Signature

☐ Please check this box to receive updates and information from your fitness program via e-mail. Your e-mail address will not be shared with any third parties and you can opt out at any time.

Please fax completed form to **1-800-327-9151.**

Office use only Member name:

Date: HP: State:

HWAZ_1 2.11

Sign-In Sheet

1425 - Rockwell Collins Recreation Center

If a member has not received his or her swipe card, has forgotten it the day of the visit or there is a problem with the tracking device, you must manually record the member's visit on this form. For problems with the tracking device that will last more than one day contact Healthways. Another method of tracking participation will be used in this case. This document must be sent to Healthways by the 5th of the month with the month-end reporting to ensure proper activity reporting. **Information on this form is required for visits to be accepted.**

Today's Date M M / D D	Healthways ID Number	Last Name, First Name (Print Legibly)
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