SCANDINAVIAN
LIVING CENTER

Strength Training Program
Physician Consent Form

Participant Name: _____

Date of Birth: _____ Telephone: _____

Dear Doctor,

Our resident has applied to participate in the Strength Training Program at the Scandinavian Living Center. Upon entering the program, the staff will determine an appropriate exercise program. Staff will supervise the participant to appropriately use weight training equipment. If you have any questions, please call our Fitness Instructor, at (617) 527-6566. You may return this form to Judith Pannesi, L.P.N., Wellness Director, by mail: 206 Waltham Street, West Newton, MA, 02465 or fax: (617) 527-2010. Thank you.

Relevant Medical Conditions: _____

Relevant Medications: _____

Precautions, Restrictions or Recommendations: _____

_____

_____

Please circle YES or NO.

This individual may participate in:

Supervised use of Strength Training Program: Keiser equipment	YES	NO
Unsupervised use of Strength Training Program: Keiser equipment	YES	NO
Supervised use or cardiovascular equipment: Nu-step	YES	NO
Unsupervised use or cardiovascular equipment: Nu-step	YES	NO

Referring physician (please print): _____

Telephone: _____

Address: _____

Physician Signature: _____ Date: _____