

HEALTHIER LIVING CENTRE/EXERCISE REGISTRATION AGREEMENT

INFORMATION

First Name:	Last Name:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Sex: (print below)
		<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	
Street Address:		Cell Phone Number: ()	Home Phone Number: ()	
P.O. Box:	City:	Province:	Postal Code:	
Health Card Number:		Date of Birth:		

IN CASE OF EMERGENCY

Name of local friend or relative (<i>not living at same address</i>):	Relationship to client:	Home Phone Number: ()	Work Phone Number: ()
Signature:		Date:	

PART-Q QUESTIONNAIRE

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active. Common sense is your best guide when you answer these questions.

Please read the questions carefully and answer each one honestly. Check **YES** or **NO**:

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
<input type="checkbox"/>	<input type="checkbox"/>	2. Do you feel pain in your chest when you do physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	3. In the past month, have you had chest pain when you were not doing physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
<input type="checkbox"/>	<input type="checkbox"/>	5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
<input type="checkbox"/>	<input type="checkbox"/>	7. Do you know of any other reason why you should not do physical activity?

*If you answered yes to one or more questions, you must obtain a physician's note indicating you are cleared to participate in an exercise class.

CLIENT COMMITMENTS

I understand that Lumacare holds the right to discharge me from a program if I fail to adhere to and follow the rules and procedures as outlined by staff members.

Initials: ____

I understand that while attending programs and services through Lumacare, photographs and/or video footage may be taken of me in order to promote the agency. These images may be published or used for any application – newspapers, posters, slide presentation or other methods of promotion, or used for educational, fundraising, informational or training purposes.

Initials: ____

The Personal Information Protection and Electronic Documents Act (PIPEDA) and the Personal Health Information Protection Act (PHIPA) require that we collect your signed consent to store your Personal Information (PI) and Personal Health Information (PHI), and to share it with others involved in planning and providing your care (if required).

I have had the opportunity to have questions answered regarding this collection and consent and feel that I have a reasonable understanding of the information. I hereby authorize the collection, use and disclosure of my Personal Information and Personal Health Information by Lumacare in order to facilitate the provision of care and service to the above mentioned.

Initials: ____

I have read, understood and completed the PAR Q Questionnaire. Any questions I had were answered to my full satisfaction. I also declare that the information above is correct and accurate.

Signature of Client:

Date:

Signature of Witness:

Date: