INFORMED CONSENT

First Name: _____ Last Name: _____

Today's Date: _____Age: _____ Date of Birth: _____ Male or Female

Informed Consent

I understand that the purpose of an exercise program is to develop and maintain cardiorespiratory fitness, muscular strength and endurance, and flexibility and balance. A specific exercise plan will be designed for me, based on my needs and interest. All exercise programs include warm-up, exercise, and cool-down. The programs include, but are not limited to aerobic exercise, strength training, and flexibility. All programs are designed to place a gradually increasing workload on the body in order to improve overall fitness. The rate of progression is regulated by the rate of my perceived effort of exercise. I understand that I am responsible for monitoring my own condition throughout the exercise program and should any symptoms occur, I would cease my participation and inform the instructor of the symptoms.

In signing this consent form, I affirm that I have read this form in its entirety and I understand the nature of the exercise program. I also affirm that my questions regarding the exercise program have been answered to my satisfaction.

In the event that medical clearance must be obtained prior to my participation in the exercise program, I agree to consult my physician and obtain written permission from my physician prior to the commencement of any exercise program.

Also, in consideration for being allowed to participate in this exercise program, I agree to assume the risk of such exercise, and further agree to hold harmless the _____, it's employees and agents, from any and all claims, suits, losses or related causes of action for damages, including, but not limited to, such claims that may result in my injury or death, accidental or otherwise, during or arising in any way from the exercise program.

*As part of your participation in the **Diabetes Exercise Program at the YMCA of Montclair**, a program for people with diabetes and pre-diabetes, we ask that you complete the requested paperwork, surveys, and functional assessments. **All responses/outcomes are kept confidential; your responses/performance will not be shared with anyone outside the DEP** program. The information you provide may be combined with other respondents answers and analyzed and reported in order to help evaluate the program effectiveness, as well as plan future programs. Thank you for your participation in the program and also for completing the surveys.*

_____ _____

Signature of participant Date

_____ _____

Contact in case of emergency Phone number

HEALTHCARE PROVIDER REFERRAL AND CONSENT

The Diabetes Exercise Program is an evidence-based program designed to reduce risk factors related to diabetes and to assist in the management of diabetes through aerobic and resistance training exercise. Classes are held two times per week for 75 minutes in addition to one independent exercise session. A nationally certified exercise specialist teaches the classes.

Participant's name _____DOB_____

Telephone _____Cellular_____

Insurance_____

Program site _____Program start date_____

The following needs to be completed by the physician and is required for exercise clearance.

Previous HbA1c lab results _____Date_____
Pre Exercise HbA1a lab Date ordered _____Results_____
(Must be within 30 days of starting the program)
Post-12- weeks HbA1c Lab Date ordered _____Results_____
(Must be in the final week or not more than 1 week after the program ends)
Please list the upper glucose level allowable for the participant to exercise_____

Exercise precautions or conditions:
Orthopedic_____
Cardiovascular_____
Respiratory_____
Neurological_____
Other_____

With these restrictions, the above-named enrollee is medically cleared to participate in the Move Well Today Diabetes Exercise Program designed for clients with pre diabetes or diabetes.

Primary care provider (print name):_____

Signature:_____Date:_____

PCP phone number:_____

MoveWell TODAY™
Diabetes Exercise Program

Date_____

HEALTH HYSTORY

Name_____ Age_____ DOB_____

Address_____

Home Phone_____ Cell_____

E-mail_____

Emergency Contact _____ Phone_____

Physician_____ Phone_____

Current physical activity level (please check one)
□ Sedentary (0-1 a week)
□ Active (15-30 min, 2-3 times a week)
□ Very active (30 + min, 4-5 times a week)

Medical history (do you have a history of any of the medical conditions?)
□ Heart disease
□ Family history of heart disease
□ High blood pressure
□ Abnormal EKG
□ Abnormal stress test
□ Congestive heart failure
□ Chest pain/angina
□ Pacemaker/defib
□ Poor leg circulation
□ Foot or uncle swelling
□ High total cholesterol
□ Stroke
□ Asthma
□ Emphysema
□ Cigarette smoking, describe
□ Shortness of breath
□ Arthritis or join pain
□ Muscle injury or disease
□ Bone or injury or disease
□ Joint replacement
□ Back pain, disk disease, spinal nerve injury
□ Overweight (20 pounds or more)

□ Osteopenia or osteoporosis
□ Diabetes
□ Insulin dependant
□ Family history of diabetes
□ Foot problems
□ Parkinson's disease
□ Dizziness or blurred vision
□ Loss of hearing
□ Vision problems
□ Cancer
□ Past surgeries

Have you fallen in the past three months? Yes□ No□
How would you rate your balance?
□ Poor
□ Good
□ Excellent

Please describe any medical conditions, diagnosis, surgeries, or symptoms not mentioned above including dates _____
_____
_____

Daily medications, dosage, and reason taken_____
_____
_____

Allergies_____
_____
_____

Additional information_____
_____
_____

DIABETES RELATED HISTORY

1. Do you routinely check blood glucose? Yes□ No□
   How often?_____

   (Habitual self-monitoring of blood glucose indicates an awareness of glycemic control. Exercise is riskier for individuals who do not monitor blood glucose and for those who do not have stable blood glucose throughout the day.)

2. Do you take insulin? Yes□ No□
   If yes, is the insulin fast-acting or slow-acting or both?_____
   Do you use an insulin pump or injections?_____

(People who take insulin are more prone to hypoglycemic reactions. In addition, the time release of the insulin is important in scheduling physical activity. People who use insulin pumps will have greater ability to adjust insulinization surrounding exercise by reducing their basal insulin rate.)

3. Do you take oral medication for diabetes?
   What types?_____
   (Sulfonylureas and meglitinides carry hypoglycemic risks)

4. Do you test your blood glucose surrounding exercise? Yes□ No□
   If yes, do you test tour blood glucose pre exercise? Yes□ No□
   During exercise? Yes□ No□
   Following exercise? Yes□ No□

   (Check blood sugar before and after exercise to avoid hyperglycemic or hypoglycemic reactions. If exercise sessions last longer than 60 to 90 minutes, check during exercise as well. This is of particular importance when beginning an exercise program or changing training parameters or medications.)

5. Have you ever had a hypoglycemic or hypoglycemic reaction? Yes□ No□
   If so, what happened and how did you feel?_____
   _____

   (Know the signs and symptoms of hypoglycemia and how to treat hypoglycemia. Wear a medic-alert bracelet indicating diabetic status in order to exercise safely.)

6. How do you treat your hypoglycemia? _____
   _____

   (Remember the 15-50 rule: 15 grams of carbohydrate should raise blood glucose levels 50 points in 15 minutes. Once glucose has normalized, a small, balanced snack containing carbohydrate, protein, and fat will assist in maintaining blood glucose level.)

7. Have you been diagnosed as having diabetes retinopathy or neuropathy in your legs or feet? Yes□ No□
   If yes, does this affect your ability to walk or perform weight-bearing exercises? Yes□ No□

   Explain_____
   _____
   _____
   _____

8. Do you have sores in your feet, between your toes, or anywhere your shoes touch?

   Explain_____
   _____

9. Do you have red marks on your feet, between your toes, or anywhere your shoes touch?

   Explain_____
   _____

10. Do any of your toes cross or overlap? Yes□ No□

11. Have you had an amputation of any of your toes or part of your toes? Yes□ No□

12. Are you currently wearing a shoe orthotic?

    (Remember that careful monitoring and observation during the exercise session should always support the health-screening process.)