



Burlington County Special Services School District  
20 Pioneer Boulevard  
Westampton NJ 08060  
609-261-5600  
[www.bcsssd.k12.nj.us](http://www.bcsssd.k12.nj.us)

## THE HEART CLUB

### DESCRIPTION OF PROGRAM

The Heart Program is a supervised exercise program for community members who have known cardiovascular disabilities and have been instructed by their physicians to change their lifestyles by including exercise to improve their physical endurance.

**ASSESSMENT:** Before beginning the exercise routine, blood pressure and resting pulse rate are measured, evaluated and recorded. Each member learns to count his/her own pulse rate although this is re-checked by the nurse for evaluation of rhythm, rate and quality. The member is encouraged to report any health problems that may prevent or hamper exertion.

**EXERCISES:**

WARM UP	10 minutes of stretching and cardiac calisthenics (as able)
AEROBIC	10 minutes stationary bicycle (at specified pulse rate)
AEROBIC	10 minutes rowing (at specified pulse rate)
AEROBIC	10 minutes walking (at specified pulse rate)
COOL DOWN	
POOL EXERCISE	OPTIONAL 30 MINUTES

**CLOTHING:** Sneakers/exercise shoes, exercise clothing, bathing suit, towel.

**DIRECTIONS** to the Burlington County Special Services School District, Westampton Township, are available. Please use the Gym Entrance Door C9 at the rear of the complex.

**GOALS:**

- To achieve physical fitness within the limits established by the attending physician.
- To improve the quality of life.
- To promote mutual support and socialization among members who share similar issues and concerns.
- To prevent exacerbation of cardiovascular disease.
- To provide a climate conducive to the maintenance of long-term healthy activity.
- To provide a continuous record of the participant's physiological response to exercise
- To provide supervision by a nurse trained in cardiac rehabilitation.
- To provide formal and informal education for modification of coronary risk factors: hyperlipidemia, hypertension, smoking and stress.

**FORMS NEEDED TO BECOME A PARTICIPANT:**

1. Letter to physician must be completed with attending physician's signature.
2. Registration Form accompanied by fee.

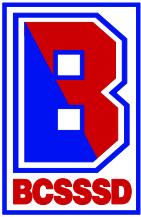
**ADDITIONAL INFORMATION:**

Days: Tuesday and Thursday, Swimming: 6:30 p.m.

Times: Session I: 4:30 p.m.

Session II: 5:00 p.m.

Session III: 5:30 p.m.



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Dear Doctor:

Your patient \_\_\_\_\_ has registered in the Burlington County Special Services School District's community based Cardiac Rehabilitation Program. This program will provide exercise sessions with physiological monitoring by Registered Nurses. Your patient will document his/her progress for you. We need the following medical information or a copy of a recent Exercise EKG (Stress) test and your permission before we can allow your patient to participate in the exercise program.

DIAGNOSIS: \_\_\_\_\_

Date of exercise EKG test \_\_\_/\_\_\_/\_\_\_ (if not done, see below)

Highest stage \_\_\_\_\_ / \_\_\_\_\_ MPH \_\_\_\_\_ % Grade

Peak heart rate achieved \_\_\_\_\_ Peak B/P \_\_\_\_\_ METS \_\_\_\_\_

Resting heart rate before test \_\_\_\_\_

Signs and Symptoms \_\_\_\_\_

Reason for terminating test \_\_\_\_\_

Medications \_\_\_\_\_

Do you give permission for your patient to exercise at his/her Target Hear Rate (THR) as derived by using Karconen's formula:  $THR = (\text{maximum heart rate \{stress test\} - resting heart rate}) \times 80\% - \text{resting heart rate}$ ?  
 American College of Sports Medicine, Guidelines for Graded Exercise Testing and Exercise Prescriptions.  
 (Philadelphia: Lea & Febriger, 1975, p. 41)

Target Heart Rate \_\_\_\_\_

*Signature, Attending Physician*

If your patient has not had and Exercise Stress Test, do you give permission to exercise at the Low Level (20 beats/minute greater than his/her rate).

Yes \_\_\_\_\_

*Signature, Attending Physician*

Date \_\_\_\_\_

SPECIAL INSTRUCTIONS:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



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## CARDIAC EXERCISE AND SWIM PROGRAM

Name of Participant \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
*Street City State Phone #*

Occupation \_\_\_\_\_

Please describe your disability:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_

Address \_\_\_\_\_ Telephone # \_ (\_\_\_\_) \_\_\_\_\_

What do you hope to accomplish through this cardiac program?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### WAIVER AND RELEASE STATEMENT

I hereby waive and release any and all rights and claims for damages I may have against the Burlington County Special Services School District, their representative and assigns for any and all suffered by the undersigned during this program.

Yes \_\_\_\_\_ No \_\_\_\_\_

On many occasions photographs are taken of participants when they are involved in various academic and non-academic activities which are an integral part of our programs. Since these photographs may be on display at various workshops, school functions can be part of a newspaper(s) and/or magazine article(s), it is necessary to have your permission to utilize your photo in a legitimate manner.

Yes \_\_\_\_\_ No \_\_\_\_\_

Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_



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THE FOLLOWING INFORMATION IS TO BE PROVIDED BY A DOCTOR

\_\_\_\_\_ is planning to enroll in a swim program for individuals with arthritis. The program is based on individualized learning; activity will be determined by the individuals with arthritis. The program is based on individualized learning; activity will be determined by the individual's specific needs. The information you provide will be most helpful and appreciated.

- 1) What joints need to be relaxed, stretched and/or strengthened:  
\_\_\_\_\_
  - 2) To what extent are these joints involved:  
\_\_\_\_\_
  - 3) Specific joint, movement or exercise to be emphasized:  
\_\_\_\_\_
  - 4) Specific joint, movement or exercise to be avoided:  
\_\_\_\_\_
  - 5) Specific precautions; tolerance problems:  
\_\_\_\_\_
  - 6) Medication or conditions of which to be aware:  
\_\_\_\_\_
  - 7) Comments \_\_\_\_\_
  - 8) Name of Doctor \_\_\_\_\_
- Address \_\_\_\_\_ Telephone # \_\_\_\_\_
- Signature of Doctor \_\_\_\_\_ Date \_\_\_\_\_

**ADULT AQUATIC PROGRAM**



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## EMERGENCY INFORMATION

Participant's Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_

Relationship to Participant \_\_\_\_\_ Telephone # \_\_\_\_\_

Physician \_\_\_\_\_ Telephone # \_\_\_\_\_

Medical conditions      Diabetes \_\_\_\_\_      Epilepsy \_\_\_\_\_      Asthma \_\_\_\_\_

Heart Condition \_\_\_\_\_ Other \_\_\_\_\_

Allergic To \_\_\_\_\_      Penicillin \_\_\_\_\_      Bees \_\_\_\_\_

Medication \_\_\_\_\_      Amount \_\_\_\_\_      How Often \_\_\_\_\_

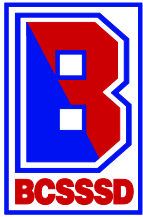
Medication \_\_\_\_\_      Amount \_\_\_\_\_      How Often \_\_\_\_\_

Medication \_\_\_\_\_      Amount \_\_\_\_\_      How Often \_\_\_\_\_

Medication \_\_\_\_\_      Amount \_\_\_\_\_      How Often \_\_\_\_\_

Medication \_\_\_\_\_      Amount \_\_\_\_\_      How Often \_\_\_\_\_

Does Participant Carry Medication?      Yes \_\_\_\_\_      No \_\_\_\_\_



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IF IMMEDIATE OBSERVATION OR TREATMENT IS URGENT IN THE JUDGEMENT OF THE SCHOOL MEDICAL PERSONNEL, I HERBY AUTHORIZE AND DIRECT THE SCHOOL TO SEND ME TO THE HOSPITAL MOST ACCESSIBLE. I AUTHORIZE SAID HOSPITAL TO INSTITUTE NECESSARY EMERGENCY CARE.

Signature \_\_\_\_\_ Date \_\_\_\_\_