Burlington County Special Services School District
20 Pioneer Boulevard
Westampton NJ 08060
609-261-5600
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)
AREOBIC	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 conductive 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 – (maximum heart rate {stress test} – resting heart rate) x 80% - 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 INFORAMTION 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 theses 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 OBSERVATIONOR 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 NECESSAY EMERGENCY CARE.

Signature _____ Date _____