

CONSENT FORM FOR THE AHDP

I fully understand that the AHDP is designed to positively affect the health, sense of well being, and health knowledge status of the older adult. As such, it involves physical and social activity, health education, and research.

I also have the right not to participate, or to withdraw from participation in the research-evaluation aspects of the AHDP.

I also understand that inherent hazards exist in any recreational, exercise and activity situation and that the AHDP cannot be held responsible for those events, including transportation to and from the AHDP site, beyond taking precautions and ensuring safety that would ordinarily be expected of professionals in a similar situation.

My signature certifies that I am participating in the AHDP of my own free will, and I am free to withdraw my consent and discontinue my participation at any time while the AHDP is in progress.

We use the last four digits of your Social Security Number as a way of identifying your responses and as a means of insuring confidentiality.

(Date)

(Your signature)

I waive my medical examination and assume all responsibility for my health/medication during the AHDP session. You are encouraged to have a medical examination yearly (see last page for a form for your physician) rather than waive it.

Date

Signature

What are you expecting from the Adult Health & Development Program?
What specific personal health & well-being goals do you have?
What activities do you enjoy?
Briefly describe your present physical condition.
From what physical activities are you restricted?
Is there anything else that we should know about you, e.g., allergies (including food and beverage allergies), dealing with depression?
Are you currently taking any medications? If yes, please list the medication and its purpose?

How far can you comfortably walk?

- Less than a mile 1 to 3 miles Over 3 miles

Check if you can participate in the following activities:

- Swimming Volleyball Dancing Progressive aerobic exercise
 Weight (resistance) training Jogging or rapid walking
 Other (List please)

What health and well-being topics would you like discussed?

- Exercise and physical fitness Intimacy and sexuality Stress Management
 Making the world a better place for children and grandchildren
 Nutrition, and losing or gaining weight Coping with arthritis
 Intelligent use of medications Grief & bereavement
 Alternative medicine (Mind-Body relationships)
 Other (Please list topics)

IN CASE OF EMERGENCY PLEASE CONTACT:

Name	
Address	
City/State/Zip	
Daytime Phone	Relationship

Name	
Address	
City/State/Zip	
Daytime Phone	Relationship

Physician's Name	
Address	
City/State/Zip	
Office Phone	Emergency Phone

PLEASE RETURN COMPLETED FORMS TO:

**AHDP - JMU
 MSC 9017
 Harrisonburg, VA 22807**

James Madison University

College of Integrated Science and Technology
Department of Social Work

Adult Health and Development Program

*****For Your Physician*****

Your (Patient’s) Name

Dear Physician: The Adult Health & Development Program (AHDP) is a physical and social activities, and health education program that runs for nine weeks. Your patient is matched with a “Staffer” (trained student) who serves as a friendly coach. The one-to-one match up over time is crucial to the AHDP process. The goal is to positively affect health, well being, physical and social activity status and health knowledge of your patient. Thus it is necessary for us to know the following (**please write or print legibly**). **Use the back of page if necessary:**

1. Can your patient participate in **physical activity**? (check highest level)
 - **Mild** (equivalent to chair exercises, regular walking, tai chi)
 - **Mid range** (equivalent to modified, low impact aerobics, more rapid walking or swimming, line dancing, mild resistance training)
 - **High level** (equivalent to jogging, low impact but higher exertion aerobics, higher level resistance training)

None ___ Comments:

2. **Blood Pressure:** Sys _____/Dia_____

3. What **physical activities are contraindicated**? What **medical problems (including psychological and social)** should we know of?

4. What **symptoms** (related to medical problems listed in #4) should we be alert to?

5. What **medication(s)** is the patient on (give name and dosage, please)?

6. Does the **medication affect mood, or physical functioning**? How? What should we be alert to?

7. If necessary, to what **hospital** shall we send your patient (please give phone number and address:

8. Is your patient **incontinent**? Yes__ No__ 10. Is your patient **violent**? Yes__ No _

Thank you.

Physician's Signature

Physician's Name (Print)

Address

Telephone number () _____ Date _____

Please return to: Nancy Owens, Director
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Harrisonburg, VA 22807
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Email: owensne@jmu.edu