



North Central District Health Department

9 Enfield - 31 North Main Street, P. O. Box 1222, Enfield, CT 06083 - (860) 745-0383 FAX 745-3188
 9 Vernon - 375 Hartford Turnpike, Room 120, Vernon, CT 06066 - (860) 872-1501 FAX 872-1531
 9 Windham - Town Hall, 979 Main Street, Willimantic, CT 06226 - (860) 465-3033 FAX 465-3032
 9 Stafford -Town Hall, 1 Main Street, Stafford Springs, CT 06076 - (860) 684-5609 FAX (860) 684-1768

William H. Blitz, M.P.H., M.U.P., R.S.
 Director of Health

Exercise/Fitness Programs

Complete and Return ALL forms in this packet by doing the following.

1. Complete and return **Class Selection**, (page 1) and the **Registration Form** (page 2).
2. You **must** submit a **Waiver of Liability** (page 3) **before** participating in the program.
3. Complete and return the attached **Questionnaire** (page 4). The **Questionnaire** is designed solely to assist in determining your physical readiness to participate in the program. Your responses are used for informational purposes only. **If you answer "yes" to any of the questions asked on the Questionnaire, you must submit a completed Statement of Health Status form (once a year) (page 5).** As noted on the form, a licensed physician, or his/her authorized physician assistant or nurse practitioner must sign this.

**Please note that North Central District Health Department recommends that all persons, no matter how they answer the Questionnaire, seek medical approval before participating in an exercise/fitness program.*

4. **Class Selection** (page 1) All classes and fees for the **Fall Session 2011** are below. Please put the fee charged in the first column for the class(es) you wish to participate in and total the column. Send your completed forms with the fee payable to North Central District Health Department (NCDHD) at least one week prior to the start of class. Mail to: P.O. Box 1222, Enfield, CT 06083-1222, or drop applications off at 31 N. Main Street, Enfield, between 8:30 a.m. - 12:00 p.m. and 12:30 p.m. - 4:30 p.m. Monday-Friday. *Suffield Class registrations must go to the Suffield Senior Center, checks still payable to: North Central District Health Department, except as noted.*

| Fee Due: | Class | Day/Time | Dates | Location | Fee | # Classes |
|--|-----------------------------|--|--|--|--|-----------|
| | East Windsor ACTIVE | Mon/Wed 10:30-11:15 am | Jan. 9 – April 2 No class Jan. 16 & Feb. 20 | East Windsor Sr. Center 125 Main Street | \$58 | 23 |
| | Enfield ACTIVE | Mon/Wed 5:30-6:15 pm | Jan. 9 – April 2 No class Jan. 16 & Feb. 20 | N. Central District Health Dept. 31 N. Main St, Enfield | \$58 | 23 |
| | Intermediate Tai Chi | Monday 7:30 – 8:30 pm | Jan. 23 –April 2 No class Jan. 16 & Feb. 20 | N. Central District Health Dept. 31 N. Main St, Enfield | \$80 | 10 |
| | “Splashin’ Action” | Tues 5:00-6:00 pm Thurs5:30-6:30 pm | Jan. 10 – March 27 | Healthtrax 3 Weymouth Rd, Enfield | \$82 | 23 |
| | Stafford ACTIVE | Mon 9:00-9:45 am | Jan. 9 – April 2 No class Jan 16 & Feb 20 | Stafford Senior Center 3 Buckley Highway | \$36 | 12 |
| | Windsor Locks ACTIVE | Tues/Thurs 8:30-9:15 am | Jan. 10 – March 27 | Windsor Locks Sr. Center 41 Oak Street | \$53 WL Residents \$57 non- residents | 23 |
| Total Fee(s) due to: North Central District Health Department P.O. Box 1222 Enfield, CT 06083-1222 | | | | | | |

Registration for the following classes must go to the Suffield Senior Center, 145 Bridge Street Phone 860-668-8830

| | | | | | | |
|--|------------------------------|----------------------------|--|--|------|----|
| | Suffield Yoga/Pilates | Mon/Wed 9:00-10:00 am | Jan. 9 – April 2 No class Jan 16 & Feb 20 | Suffield Sr. Center 145 Bridge Street | \$58 | 23 |
| | Suffield ACTIVE | Mon/Wed 10:10–11:10 am | Jan. 9 – April 2 No class Jan 16 & Feb 20 | Suffield Sr. Center 145 Bridge Street | \$58 | 23 |
| | Suffield Yoga | Saturdays 9:00-10:00 am | Jan. 7 – Feb. 11 | Suffield Sr. Center 145 Bridge Street | \$30 | 6 |

We hope that you choose to take advantage of and enjoy these programs!

Please call our Enfield office at (860) 745-0383 if additional information is needed.



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ACTIVE Registration Form
Winter Session 2012
(Please Print)

Class _____

Name _____

Address _____

Town: _____ State _____ Zip _____

Daytime Phone No. _____ Home Phone No. (if different from daytime #) _____

Age _____ Male _____ Female _____

Returning Member New Member; Referred by: _____

Non-Hispanic Origin:

White Black Asian/P Amer. Ind. Other/Unk

Hispanic Origin:

White Black Other/Unk.

Physician: Name _____ Phone _____

Address _____

Emergency Contacts:

1. Name _____ Relationship _____ Phone _____

2. Name _____ Relationship _____ Phone _____

Please list your goals for this program in order of priority:

1. _____

2. _____

How did you learn about the ACTIVE Program?

_____ Newspaper _____ Flyer/Poster _____ Television/Radio _____ Letter _____ Friend/Word of Mouth

I intend to commit myself to attending the scheduled ACTIVE classes on a regular basis, except in cases of illness, familial obligation or hazardous weather conditions. A missed class can be made up by attending any of our other ACTIVE class locations. Cancellation policy: if the public schools located in the town of your class location are dismissed early or cancelled, ACTIVE is cancelled. Refer to Radio Station WTIC, or TV channels WFSB 3 or WVIT 30 for cancellations.

Signed: _____ Date _____



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A.C.T.I.V.E./ EXERCISE PROGRAM

WAIVER OF LIABILITY 2012 – Winter Session

I, _____, hereby release North Central District Health Department and its respective employees and agents from any and all liability or responsibility of any injury to me which arises either directly or indirectly as a result of my participation in any exercise or fitness program offered, conducted, sponsored, or recommended by North Central District Health Department or its employees or agents.

I acknowledge that my participation in these activities is purely voluntary, that participation is undertaken at my own risk, and that I have been advised by North Central District Health Department to consult with my doctor before participating in any of these activities.

Signature

Date

7/26/11



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QUESTIONNAIRE REGARDING EXERCISE/HEALTH PROGRAM

The following questionnaire is designed to assist in determining your physical readiness to participate in a new exercise/fitness program. Your responses are used for informational purposes only. *North Central District Health Department advises all persons to seek medical approval before undertaking a new exercise/fitness program.*

1. Your doctor said you have a heart condition and recommended only medically supervised physical activity. _____Yes _____No
2. During or right after you exercise, you frequently have pains or pressure in the left or mid-chest area, left neck, shoulder or arm. _____Yes _____No
3. You have developed chest pain within the last month. _____Yes _____No
4. You tend to lose consciousness or fall over due to dizziness. _____Yes _____No
5. You feel extremely breathless after mild exertion? _____Yes _____No
6. Your doctor recommended you take medication for your blood pressure or a heart condition. _____Yes _____No
7. Your doctor said you have bone or joint problems that could be made worse by the proposed physical activity. _____Yes _____No
8. You have a medical condition or other physical reason not mentioned here which might need special attention in an exercise program. (For example, insulin dependent diabetes). _____Yes _____No
9. You are middle-aged or older, have not been physically active, and plan a relatively vigorous exercise program. _____Yes _____No

Signature

Date

Please be advised that North Central District Health Department does not render medical advice and does not assume any liability for providing this questionnaire. Regardless of your responses above, North Central District Health Department recommends that you seek medical approval before participating in a new exercise/fitness program.



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STATEMENT OF HEALTH STATUS

Name of Person: _____

Address: _____

Date of Health Status Statement: _____

This is to certify that I have found the above-named person to be in good health and free of health problems that would prevent him/her from participating in a light to moderate aerobic and strength, physical activity program.

Signature of physician: _____

Address: _____

Phone Number: _____

This statement may be signed by a licensed physician or his/her authorized physician assistant or nurse practitioner.

7/26/11