Penn Medicine
Lancaster General Health

Patient Name: _____

MRN: _____

Date of Birth: _____

Complete above information or attach patient label to each page.

CONSENT FOR PARTICIPATION IN ACTIVATE KIDS!

CHILD NAME: _____ Birthdate: _____

ADULT NAME: _____ Birthdate: _____

ADULT NAME: _____ Birthdate: _____

Address: _____

Phone Number: _____ Email Address: _____

1. PURPOSE AND EXPLANATION OF PROGRAM

Activate Kids! is a program that focuses on exercise, nutrition, and emotional wellbeing. Activate Kids! is designed to improve the health and quality of life for the participants and their family.

2. CONSENT TO PARTICIPATE

I hereby voluntarily consent to participate in this 8-week program with my child. I understand that I am expected to attend every session.

3. EXERCISE RISKS

The levels of exercise performed will be based upon the participants' fitness levels.

My child's physician has cleared him or her for exercise and has noted any restrictions. I agree to inform the program staff if there are health changes during the program.

The participating adult is also expected to exercise. I will inform program staff of exercise restrictions or concerns that prevent or limit me from exercising.

I will be given instructions regarding the amount and kind of exercise my child and I should do. A fitness professional will provide leadership to direct our activities, monitor my performance, and otherwise evaluate our effort. Depending upon our health status, we may or may not be required to have our blood pressure and heart rate evaluated during these sessions to regulate our exercise within desired limits.

We will be given the opportunity for periodic assessment and evaluation at regular intervals after the start of the program. I have been informed that during our participation in the fitness program, we will be asked to complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort, or similar occurrences appear. I have been advised that it is our right to decrease or stop exercise and that it is my obligation to inform the personnel of symptoms, should any develop.

I understand that during the performance of exercise, the fitness professional will periodically monitor our performance and possibly measure our pulse, blood pressure, or assess my feelings of effort. I also understand that the fitness professional may reduce or stop my exercise program when any of these findings so indicate that this should be done for our safety and benefit.

I understand and I have been informed that there exists the remote possibility during exercise of adverse changes including, but not limited to, abnormal blood pressure, fainting, dizziness, heart rhythm disorders, and in very rare instances heart attack, stroke, or even death. I further understand and I have been informed that there exists the risk of bodily injury including, but not limited to, injuries to the muscles, ligaments, tendons, and joints of the body.

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Every effort will be made to minimize these occurrences by proper staff assessments of the participants' condition before each physical activity session, staff supervision during exercise and by the participants' own careful control of exercise efforts. I fully understand the risks associated with exercise, including the risk of bodily injury, heart attack, stroke or even death, but knowing these risks, it is my desire to participate with my child as indicated.

Should an emergency arise, I consent to receiving medical treatment for myself and my child as necessary.

4. CONFIDENTIALITY AND USE OF INFORMATION

I have been informed that the information obtained in Activate Kids! is privileged and confidential.

My and my child's health information may be used and disclosed as described in the Lancaster General Health Notice of Privacy Practices. I have been provided or have previously received a copy of the Notice of Privacy Practices.

Health concerns and a summary of the child's participation in Activate Kids! will be sent to his or her health care provider.

5. INQUIRIES AND FREEDOM OF CONSENT

I have been given an opportunity to ask questions about the program.

I have read this form, fully understand its terms, and sign it freely and voluntarily, without inducement.

_____
Child Printed Name

_____ _____ _____
Parent or Legally Authorized Representative Signature Date Time

_____
Patient or Legally Authorized Representative Printed Name

_____ _____ _____
Parent or Legally Authorized Representative Signature Date Time

_____
Patient or Legally Authorized Representative Printed Name