Your patient wishes to start a personalized prenatal exercise program tailored to healthy pregnant women. The program includes:

- Wellness Center Membership – involves aerobic and resistive exercise in the Wellness center.
- Pilates Momma and Yoga Momma – focuses on breathing and various poses.

Please evaluate your patient and inform her of any restrictions you may recommend. Your initial approval will be in effect for the duration of your patient’s pregnancy. If health changes occur, please advise patient that a re-evaluation is needed. Please indicate below your approval of your patient’s participation in the prenatal exercise class:

**HEALTH CARE PROVIDER** - Please sign the statement that reflects your wishes:

- This patient may participate without any restriction in the Wellness Center Membership
- This patient may participate without any restriction in Pilates Momma and/or Yoga Momma
- This patient may proceed in the prenatal exercise program with the following restrictions:

  ______________________________________________________
  ______________________________________________________
  ______________________________________________________

Health Care Provider’s signature: ____________________________ Date: ____________

Please return to Wellspring, 90 Oak Street, Prairie du Sac, WI 53578
Phone: 608-643-7572; Fax: 608-643-7667; Email: wellspring@saukprairiehealthcare.org
PRENATAL EXERCISE PROGRAM – HEALTH QUESTIONNAIRE

NAME: ________________________ DOB: ____________ TODAY’S DATE: ______________

CELL PHONE: ____________________ OTHER PHONE: _______________________

PHYSICIAN’S NAME: ______________________ DUE DATE: __________________

Do you have:
☐ Yes ☐ No Heart problems
☐ Yes ☐ No High blood pressure
☐ Yes ☐ No Lung problems
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Seizures
☐ Yes ☐ No Dizziness or loss of balance
☐ Yes ☐ No High blood cholesterol
☐ Yes ☐ No Difficulty exercising
☐ Yes ☐ No Muscle, bone, joint problems or back disorders
☐ Yes ☐ No Chronic illness
☐ Yes ☐ No Advice from a physician not to exercise
☐ Yes ☐ No Surgery within the last 3 months

If you answered YES to any of the above questions, please explain.

____________________________________________________________

Any other medical problems?

What medications are you currently taking?

What is your current exercise program?

Please return to Wellspring, 90 Oak Street, Prairie du Sac, WI 53578
Phone: 608-64-7572; Fax: 608-643-7667; Email: wellspring@saukprairiehealthcare.org
CONSENT FORM

Thank you for choosing the Sauk Prairie Healthcare Wellspring Center. We request your understanding and cooperation in maintaining both your and our safety and health by reading and signing the following release from liability.

In consideration of gaining membership or being allowed to participate in the activities, services and programs of the Sauk Prairie Healthcare Wellspring Center and to use its facilities, equipment and machinery in addition to the payment and fees or charge, I do hereby waive, release and forever discharge Sauk Prairie Healthcare Wellspring Center and its officers, agents, employees representatives, executors and all others from any and all responsibilities or liability for injuries or damages resulting from my participation in any activities, services and programs or my use of the equipment or machinery in the above-mentioned facilities or arising out of my participation in any of the activities, services and programs at said facility. I do hereby release all of those mentioned and any others acting upon their behalf from responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities, services and programs of Sauk Prairie Healthcare Wellspring Center or use of any equipment at Sauk Prairie Healthcare Wellspring Center.

I understand and am aware that the strength, flexibility and aerobic exercise, including the use of equipment is a potentially hazardous activity. I also understand that the fitness activities involve a risk of injury and even death and that I am voluntarily participating in these activities, services and programs and using the equipment and machinery with the knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

I do hereby further declare myself to be physically sound and suffering from no conditions, impairment, disease, infirmity or other illness that would prevent my participation in any of the activities, services and programs of Sauk Prairie Healthcare Wellspring Center or use of equipment or machinery except as hereinafter stated. I do acknowledge that I have been informed of the need for a physician’s approval for my participation in an exercise fitness activity, service or program or use of equipment or machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, and the use of exercise and training equipment so that I might have recommendations concerning these fitness activities, services and programs and equipment use. I acknowledge that I have either had a physical examination and have been given any physician’s permission to participate or that I have decided to participate in the activities, services and programs and/or the use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation in the activities, services and programs, and utilization of equipment and machinery in my activities.

I declare that I have read, understood and agreed to the contents of this release from liability. Individuals under the age of 18 require a parent’s signature.

Name (please print)__________________________________________________________

Signature: ______________________________ Date: ____________________________

Parent Signature (if under 18): ____________________________________________