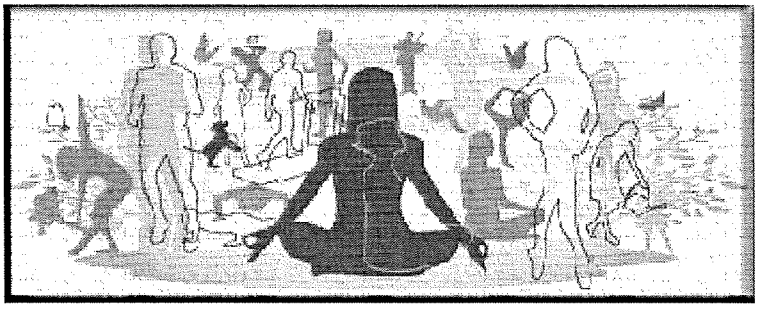
VISITING NURSE ASSOCIATION
OF CAPE COD
Member Cape Cod Healthcare

VNA of Cape Cod Wellness Programs

Participant Information Sheet



Participant Section:

I, _____, understand that I will be participating in the VNA of Cape Cod's Wellness programs, and to the best of my ability, I will attend every session of the program. I am also responsible to inform the staff of my health status each session.
If symptoms of distress, chest pain or other ailments are present, I understand that I will not be able to participate that given day. In addition, I hereby release Cape Cod Healthcare, its affiliates, and employees from any liability whatsoever occasioned by my participation in the programs.

SIGNED: _____ DATE: _____

PRINT NAME: _____ PHONE: ( ) _____

ADDRESS: _____ D.O.B. _____

CITY,STATE,ZIP: _____

EMERG CONTACT: _____ PHONE: ( ) _____

RELATIONSHIP: _____ PHONE: ( ) _____

******* This form along with the Medical clearance form from your physician is required to be returned to this office **prior to your participation in the program.**

This form is good for a period of 1 (one) year from above date.

~ VNA of Cape Cod ~ 434 Route 134, Suite G-1, South Dennis, MA 02660
Phone toll free: 1-800-631-3900 x 7423 or direct 508-957-7423 **FAX: 508-394-2109**