Children's HOSPITAL • ST. LOUIS
BJC HealthCare™

HEAD TO TOE PROGRAM –

ADULT PARTICIPANT

INFORMATION & CONSENT

********PLEASE BRING WITH YOU TO THE FIRST CLASS********

The Head-to-Toe Program is a specialized weight management program developed by St. Louis Children's Hospital for children (8–17 years of age) and their caregivers to learn how proper diet and exercise are crucial to maintaining a healthy lifestyle. The Head-to-Toe Program offers families an interactive learning environment with a wide variety of opportunities to engage in discussion with healthcare professionals and other families concerning diet, exercise and healthy living habits. The goal of the Head-to-Toe Program is to help children and their families learn the tenets of proper diet and exercise in order to obtain/maintain proper weight, which, in turn, helps to maintain a good self-image and self-esteem.

As part of the Head-to-Toe Program, we need to have certain background and medical information concerning you so that you can exercise with your child. If you decide to participate in the Program, please read and complete the below information and bring this form to the first Head-to-Toe Program class. If you have any questions, please do not hesitate to contact us at (314) 286-0961.

ADULT PARTICIPANT INFORMATION: Name: _____

Relationship to Participating Child: ☐ Parent ☐ Grandparent ☐ Other _____

Age Range (yrs): ☐ <40 ☐ <50 ☐ <60 ☐ >60

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____

Physician's Name: _____ Phone: _____

Physician's address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (*Please Indicate*)

	Yes	No		Yes	No		Yes	No
Heart trouble	☐	☐	Broken bones	☐	☐	Dislocation of joint	☐	☐
Kidney trouble	☐	☐	Back pain/injury	☐	☐	Muscle, joint or ligament sprain	☐	☐
Diabetes	☐	☐	Shoulder/ elbow /wrist problems	☐	☐	Fainting / dizziness	☐	☐
Asthma	☐	☐	Epilepsy	☐	☐	Hip, knee or ankle problems	☐	☐
Severe headaches	☐	☐	Head injury	☐	☐	Food allergy	☐	☐

1) If you answered "Yes" to any of the above questions or if you have any other health problems, please list those concerns or problems: _____

_____

2) Are you presently under a doctor's care for any condition? Yes ☐ No ☐

If "Yes", please state the nature of the condition and treatment: _____

_____

3) Are there any other medical conditions that you feel may affect your ability to participate in the Program? _____

_____

If You answered YES to any of above questions - Please request a physician's release to permit your participation and exercise with a Fitness Specialist, who will assess your basic fitness level and plan activities accordingly.

HEAD TO TOE PROGRAM

PLEASE NOTE: If any of your responses to the questions above change or new conditions occur that may affect your ability to participate in the Head-to-Toe Program, please contact the Head-to-Toe Program Supervisor and/or facilitators of the change or new condition.

CONSENT TO PARTICIPATE IN HEAD-TO-TOE PROGRAM

The Head-to-Toe Program provides education and instruction to children and their families on important lifestyle habits and weight management. I understand that our family will be learning healthy lifestyle habits, including nutritional counseling and exercise instruction, from various health care professionals. As a participant in the Head-to-Toe Program, we will participate in exercises to help us achieve identified weight goals and may feel muscle soreness or other exercise related discomfort. As with any exercise program, a physician's evaluation of your ability to participate in the exercise program is recommended.

With knowledge of the purpose and goals of the Head-to-Toe Program, I give my permission and consent for me, _____, to participate in the Head-to-Toe Program with my child to obtain diet/nutritional counseling as well as instruction on and participation in an exercise program.

I also give permission for images of me and my child, captured during regular and special Head-to-Toe activities through video, photo, and digital camera to be used solely for the purposes of St. Louis Children's Hospital promotional material and publications, and waive any rights of compensation or ownership thereto.

The information contained in the Physical Activity Questionnaire is accurate and complete to the best of my knowledge.

Participant Signature: _____ Date: _____

(*Print name*) _____

ACKNOWLEDGMENT OF RECEIPT - NOTICE OF PRIVACY PRACTICES:

I have received or I have been given the opportunity to receive a copy of St. Louis Children's Hospital "Notice of Privacy Practices" that explains when, where and why my confidential information may be used or shared. I acknowledge that St. Louis Children's Hospital, the physicians, the nurse and other St. Louis Children's Hospital staff may use and share my confidential health information with others to treat my child, in order to arrange for payment of my bill and for issues that concern St. Louis Children's Hospital's operations and responsibilities.

Participant **Signature**: _____ Date: _____