PARTICIPANT ENROLLMENT FORM
Tai Chi For Diabetes

_________________________________________  Zipcode:_________________________

Telephone: (H)_________________________  (W):_________________________

Contact person in case of emergency: ____________________________________________

Telephone: (H)_________________________  (W):_________________________

I have read the Tai Chi for Diabetes Program Guidelines and understand that there is an inherent risk in any exercise or activity. I agree to abide by the rules set out in the Program Guidelines. I have no medical contraindication to participating in this workshop. I understand that if I do have any medical contraindication, then it is my responsibility to obtain clearance from my doctor before commencing the workshop.

Signature: ___________________________ Date: ___________________________

PROGRAM GUIDELINES

- Classes are open to any suitable person as specified per brochure, provided they are medically fit, can independently dress, are independently mobile and can participate without assistance in the class.

- Classes usually last one hour. Participants are encouraged to rest at any time if needed and to work within their own comfort zone at all times.

- Participants are required to do gentle warm-up exercises before they start and cool-down exercises afterward.

- The Tai Chi exercises in this program are similar to walking in terms of physical exertion.

- Any participant who has any doubt about whether they are medically fit to attend the workshop is required to have medical clearance from their doctor prior to commencing the workshop.

- Designed by Tai Chi and medical experts. Led by Dr. Paul Lam and supported by the Diabetes Foundation of Australia.

- Classes are conducted by certified Tai Chi for Diabetes instructors.

For TCD Co-ordinator Use Only

Instructions: ________________________________________________________________

Signature: ___________________________ Date: ___________________________
DOCTOR’S APPROVAL FORM
Tai Chi For Diabetes Program

Doctor’s Name: .................................................................

Address:...........................................................................

........................................................................... Zipcode: ..........................................

Telephone: ................................................................. Fax: ..........................................

Thank you for providing the following information about your patient who wishes to join the Tai Chi for Diabetes Program. All information is strictly confidential and will only be available to class leaders. This information is used to provide instructors with accurate information in case of emergency, and for appropriate exercise selection.

- Type of diabetes: .................................................................

- Area of special care: .................................................................

Does this patient require an assessment by a dietitian prior to entering the Tai Chi for Diabetes program? Yes □ No □

Are there any type of exercises which should be avoided? Yes □ No □
If Yes, name these exercises: ..............................................................................

Is there any other relevant information which might affect treatment in an emergency situation?

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I advise that ......................... is medically fit to participate in the Tai Chi for Diabetes program. I have read the "Fact Sheet for Health Care Professionals."

Doctor’s Signature: ................................................................. Date: .............................................