

WELLNESS PROGRAM INSTRUCTIONS FOR PAPERWORK

The attachments you receive need to be filled out carefully. The deadline for paperwork will be sent with the attachments. Please direct any questions/concerns to me through e-mail. Thanks. Ginny Rappleyea

- 1) Applicant's Health History fill out and sign; blank which says "reviewed by" is for Patterson Army Health personnel. Leave "reviewed by" blank. Return with packet.
 - 2) Health History/Risk Factors fill out and sign; same treatment of "reviewed by" blank. Return with packet.
 - 3) Symptom Inventory Checklist your name and information about your doctor are required at the top. Fill that in as well as the rest of the form and return with packet.
 - 4) Physician's Approval. Provide your doctors name. Have your doctor sign this sheet and return with packet.
 - 5) Liability Form. Your signature is required on this. Return with packet.
 - 6) Guidelines. For you and your supervisor. No return required.
 - 7) Employee-Supervisor Agreement. Work this your supervisor according to your workload/office needs, ect. You and your supervisor both sign this Return it with the packet.
 - 8) Fitness Assessment. Put your name and age at the top. Your doctor needs to give you the information for your cholesterol and your glucose readings. If you've had a blood test within the last 6 months, your readings ought to be pretty accurate. Return with packet.
 - 9) Goal Sheet. Put your name and phone number at the top. Just fill out your long-term goal and return with packet.
 - 10) Database. Please fill this out with the required information and return with the packet.
- **By mail, you'll be getting a "Medical Record" form. Just fill out your doctor's name, address and phone number and your name in the second blank. Return with packet.**
- **Verification Log. This is an important paper. Make 5 copies of it and keep it with your wellness folder. Each time you see 1 hour for exercise, provide the date, activity, time spent, the initials of either your supervisor or someone at the gym (if that's where you are exercising). At the end of the month, fax this Verification Log to me at X21598.**

FORT MONMOUTH Workforce Wellness Program

***This form has to be returned in the complete packet.**

APPLICANT'S HEALTH HISTORY

1. Name _____ Dept/Sec _____

2. Work Phone _____

3. Sex/Age _____ M _____ F Age _____

4. Are you currently taking any medication or drugs? _____ Y _____ N

If yes, please list what you are taking _____

5. Do you currently exercise regularly? _____ Y _____ N

6. Do you have, or have you had any of the following? (Indicate Y or N)

_____ History of heart problems, chest pain or stroke

_____ High Blood Pressure

_____ Any chronic illness or condition (If Y, describe briefly) _____

_____ Difficulty with physical exercise (If Y, describe briefly) _____

_____ Advice from physician not to exercise

_____ Recent surgery (within the last 6 months)

_____ Pregnancy (now or within the last 3 months)

_____ History of breathing or lung problems *(allergies, asthma)

___ Muscle, joint or back disorder or previous injury still affecting you

___ Diabetes or thyroid condition

___ Obesity (more than 20 pounds over ideal weight)

___ History of heart problems in your immediate family

7. Do you currently smoke? ___ Yes ___ No

8. Have you tried to quit? ___ Yes ___ No

9. How many years have you smoked? ___

10. How many cigarettes a day do you smoke? ___

11. What is it that you hope to accomplish through a wellness program?

APPLICANT'S SIGNATURE _____ DATE _____

Reviewed by _____ DATE _____

(Patterson Army
Clinic Staff)

- **Please return this form with your packet**

FORT MONMOUTH Workforce Wellness Program

Health History/Risk Factors

(Please return this form to the Wellness Coordinator's Office)

1. Name _____ Directorate/Sect. _____

2. Work Phone _____ 3. Sex ___M___ ___F___

4. Emergency Contact: Name _____

Relationship _____ Phone _____

5. Are you currently taking medication? ___Y___ ___N___

If yes, please list here: _____

6. Do you currently exercise regularly? ___Y___ ___N___

If yes, please describe _____

Activity _____ Times per week _____ Amt. Of time _____

7. Do you have or have you had any of the following (Y=Yes, N=No)

History of heart problems, chest pain or stroke _____

High blood Pressure _____

Any chronic illness or condition _____

Difficulty with physical exercise _____

Advice from physician not to exercise _____

Recent surgery (last 6 months) _____

Pregnancy (now or within last 3 months) _____

History of breathing or lung problems _____

Muscle, joint or back disorder or any previous injury _____

Still affecting you _____

Diabetes or thyroid condition _____

Obesity (more than 20lbs over ideal weight) _____

History of heart problems in immediate family _____

8. Do you currently smoke? ___Y___ ___N___

If yes, how many cigarettes/day _____

SIGNATURE: _____

DATE: _____

Reviewed by _____

DATE: _____

FORT MONMOUTH Workforce Wellness Program
SYMPTOM INVENTORY CHECKLIST

**Please return this form with your packet. Respond only for tests/medication, etc. that you have had or are currently taking.

LAST NAME

FIRST NAME

DATE

Name, Address & Phone number of current physician and/or cardiologist

A. CARDIAC HISTORY

Have you had (check all that apply)

DATE

- | | | | |
|--|------------|--------------|-----|
| 1. Electrocardiogram (EKG) | ___ Normal | ___ Abnormal | ___ |
| 2. Exercise treadmill Test (ETT) | ___ Normal | ___ Abnormal | ___ |
| 3. Nuclear Medicine (thallium) test | ___ Normal | ___ Abnormal | ___ |
| 4. Angina or 4a. Chest pain within the last 6 months | ___ Normal | ___ Abnormal | ___ |
| 5. Myocardial Infarction (heart attack) | | | ___ |
| 6. Angiogram (heart catheterization) | ___ Normal | ___ Abnormal | ___ |
| 7. Coronary Angioplasty (balloon) | ___ Normal | ___ Abnormal | ___ |
| 8. Coronary Atherectomy (plaque removal) | ___ Normal | ___ Abnormal | ___ |
| 9. Coronary Stent | ___ Normal | ___ Abnormal | ___ |
| 10. Coronary Bypass Surgery | ___ Normal | ___ Abnormal | ___ |
| 11. Congestive Heart Failure (CHF) | | | ___ |
| 12. Valvular Heart Disease, repair and/or replacement | | | ___ |
| 13. Stroke (cerebrovascular accident) | | | ___ |

If you have been hospitalized for any of the above, please indicate the of the hospital and physician who treated you.

FAMILY MEDICAL HISTORY

Does/did any parent, aunt, uncle (1st generation) or sibling (blood) have a history of the following (check all that apply): Indicate which family member and what age at diagnosis.

Please place a check mark

DATE

- 1. Heart Attack (myocardial infarction)
- 2. Coronary bypass surgery
- 3. Coronary Angioplasty, Stent, Atherectomy
- 4. Hypertension (high blood pressure)
- 5. High Cholesterol or Blood Lipids
- 6. Cancer
- 7. Diabetes

MEDICATIONS:

Do you take the following medications, or have you taken them as treatment in the past?
(Please check all that apply)

| | Medication | Dosage | # per day |
|---|------------|--------|-----------|
| <input type="checkbox"/> 1. Cholesterol lowering drugs | _____ | _____ | _____ |
| <input type="checkbox"/> 2. Aspirin, Advil, similar drugs (not Tylenol) | _____ | _____ | _____ |
| <input type="checkbox"/> 3. Blood pressure lowering drugs | _____ | _____ | _____ |
| <input type="checkbox"/> 4. Blood thinning drugs | _____ | _____ | _____ |
| <input type="checkbox"/> 5. Thyroid medication | _____ | _____ | _____ |
| <input type="checkbox"/> 6. Immunosuppressive drugs | _____ | _____ | _____ |
| <input type="checkbox"/> 7. Any other medication (answer below) | _____ | _____ | _____ |

Please list all other current medications. Include any over-the-counter medications, vitamins and supplements (incl. Herbal. Body-building supplements). Also include dosage and frequency.

FOR WOMEN ONLY: _____ Pre-menopausal Menopause Status
 _____ Menopausal _____ Post Menopause (age at menopause _____)

| Name of Medication | Dosage | #times/day |
|--------------------|--------|------------|
|--------------------|--------|------------|

Do you take:

| | | | |
|----------------------------|-------|-------|-------|
| _____ Hormonal Medications | _____ | _____ | _____ |
| _____ Estrogen Replacement | _____ | _____ | _____ |
| _____ Birth Control pills | _____ | _____ | _____ |

OTHER MEDICAL CONSIDERATIONS

Have you ever been treated for disease, condition or symptom related to the following?
 (Check all appropriate)

1. Pulmonary (lungs) _____
2. Arthritic/muscular _____
3. Endocrine (thyroid, hormonal) _____
4. Liver _____
5. Gastrontestinal (colon, stomach) _____
6. Skin (dermatological) _____
7. Nervous system (brain) _____
8. Cancer (neoplasm) _____
9. Trauma _____
10. Hematologic (blood disorders) _____
11. Ophthalmologic (eye) _____
12. Ear, nose or throat _____
13. Kidneys, bladder, reproductive organs _____

14. Allergies/sensitivities/drug reactions

15. Thyroid Condition

16. Diabetes

17. High Blood Pressure

18. High Cholesterol

19. Other

FORT MONMOUTH WORKFORCE WELLNESS PROGRAM
Please have your physician fill this out. Please return it in your packet.
PHYSICIAN'S APPROVAL FORM

Patient Name: _____

Has medical approval to participate in the physical fitness component of the Fort Monmouth Workforce Wellness Program. I understand that the program includes mild and moderate intensity group or unsupervised individual physical activity, done on a voluntary basis during which the participant may stop and rest at any time.

THE FOLLOWING RESTRICTIONS MAY APPLY (If none, so state)

Physician's Signature _____

Date _____

Physician's Name (printed) _____

Office Telephone Number _____

FORT MONMOUTH WORKFORCE WELLNESS PROGRAM

Please return this with your application packet

RELEASE OF LIABILITY

For Participation in Workforce Wellness Program

I, _____, am about to voluntarily participate in a fitness/wellness program sponsored by Fort Monmouth's Morale, Welfare & Recreation Directorate. I am fully aware of the possible risks of personal injury, illness and property damage associated with the activities in which I intend to participate, and acknowledge that I am assuming both the responsibility for safeguarding myself and my property as well as the risk of any injury, damage or loss that may occur as a result of my participation.

In consideration for the permission given to me by the United States and the U.S. Army through its officers, agents and employees, I hereby release and forever discharge the United States and the U.S. Army, and the Morale, Welfare & Recreation Directorate and all of its officers, agents, employees and volunteer staff, acting officially or otherwise, from any and all claims for personal injury, illness or death or for loss damage to personal property which may occur as a consequence of my participation in this program as well as any activity incidental to my participation. I further agree that neither I nor my heirs, administrators, executors, and assignees will ever prosecute or in any way aid in prosecuting any demand, claim, or suit against the United States Government, the U.S. Army and the Morale, Welfare and Recreation Directorate and all of its officers, agents, employees and volunteer staff acting officially or otherwise for personal injury, death or property loss or damage as a consequence of my participation in the program.

DATE _____ SIGNATURE _____

FORT MONMOUTH WORKFORCE WELLNESS PROGRAM
TARGETING FITNESS INFORMED CONSENT
(For Health Promotion Program Assessment & Activities to be conducted at
Ft. Monmouth's Physical Fitness Center)

THIS FORM HAS TO BE SIGNED, WITNESSED AND RETURNED.

The undersigned hereby gives informed consent to change in a series of health and medical evaluations including an exercise test to determine my physical fitness and health status. Exercise testing may be performed in a health and fitness center setting by a variety of means. Individuals trained in administration of the test will conduct the voluntary target fitness program assessment. The assessment will include the following:

1. **Blood Glucose and Cholesterol Level** testing completed by your own physician.
2. **Body Composition** will be determined by a variety of assessment methods:
 - **Body weight & height** will be measured on a standard medical scale:
 - **Waist to Hip ratio** – measuring the circumference of the hip and waist with a tape measure and determining their relationship. This assessment is optional.
 - **Skin fold Clipper device** to measure the thickness of substantial fat stores under the skin. Three sites will be taken to estimate the over all body fat.
2. **Cardiorespiratory Screening** will provide an estimate of the cardiorespiratory fitness of the individual. Cardiorespiratory fitness is defined as the ability of the heart and lungs to provide oxygen to the muscles. The tests below are not valid nor should they be administered to individuals taking medications that affect heart rate. Cardiorespiratory screening will be done by either of the following methods:
 - **3 minute step test** may be used as one method. The purpose of the step test is to measure the heart rate in the recovery period following three minutes of stepping. The results of the step test provide an indication of the cardiorespiratory fitness of the individual and can be used to demonstrate an individual's progress. The recovery heart rate becomes lower indicating a more efficient heart.
 - **One Mile Walk Test** is another method to measure the heart rate in the recovery period following: **A one-mile walk** and comparing it to the time it takes to walk the one mile. The test provides the individual with a general assessment of cardiorespiratory fitness. The tester or the tested may stop any of the tests should symptoms of pain, fatigue, breathlessness or any other symptoms dictate.
4. **Maximum Chest Press and Leg Press Test and One Minute Push-up and Sit-up Test** will be used to measure muscular strength and endurance. Respectively. The chest and push up test measure the strength of the thigh and buttock muscles. Muscular strength is defined as the amount of tension that a muscle can generate in one maximum effort contraction. The sit-up test measures the endurance is defined as the ability to contract a muscle repeatedly over a period of time. **If you have a back, shoulder or knee problems, please make the tester aware before beginning the test.** The tester or the tested may stop the test should symptoms of pain, fatigue, breathlessness, or other symptoms dictate.

5. **Sit and Reach Test** measures flexibility of the muscles in the back of the legs and trunk. Flexibility is defined as the range of possible movement in a joint or group of joints. The test may be stopped by the tester or tested should symptoms of pain, fatigue or other symptoms dictate.

The entire testing procedure should take no more than one hour of my time. I realize that I may withdraw from the program at any time at no prejudice to me. The benefits of such testing are the scientific assessment of physical fitness and the appraisal of health hazards, which may facilitate prescription of my exercise and other lifestyle habits. All records and results from this testing will be held in strict confidence unless my consent is obtained.

I understand that trained health promotion specialists will supervise directly or indirectly, the wellness program in which I will participate. There may be some slight risk associated with the exercise program, there is a chance that some cardiovascular problem could develop or in very rare instances a heart attack could occur. Excessive exercise in hot, humid conditions can lead to heat injury such as heat exhaustion or heat stroke. This danger can be reduced by altering my exercise program during hot and humid weather by drinking plenty of water and by recognizing the early signs of heat injury. Careful medical screening prior to entering the program minimizes these risks. If further diagnostic or therapeutic care is needed, I understand that it is my financial responsibility.

There are numerous benefits to participation in wellness program. I will learn how to improve my diet, lose weight, manage stress and how to exercise safely and effectively. Improving health practices is thought to improve my overall health status and functional ability.

I have has a chance to have my questions answered to my satisfaction about this program. I understand that if I have additional questions, I may contact the Fort Monmouth Workforce Wellness Coordinator.

SIGNATURE

DATE

WITNESS

FORT MONMOUTH WORKFORCE WELLNESS PROGRAM

Guidelines for Participants & Supervisors

Please retain this form for periodic reference

1. Eligibility

- a. Open to all civilian employees, family members, reserve & active duty.
- b. The program is completely voluntary.
- c. Participation is limited to one six month period.
- d. Participants must complete all required paperwork and turn it in at the Wellness Program Coordinator's office on order to be considered eligible.

2. Participants' Responsibilities

- a. **ALL** participants are required to complete medical clearances, health history questionnaires, physician referral forms, ect. All health related information is confidential and will be kept on file at PACH.
- b. Program start and end dates will be provided to each participant for the completion of the contract with his or her supervisor for attendance in the exercise portion of the program. While, in most cases, the start-end dates will be universal for all participants, outside factors may require flexibility in this requirement.
- c. Participants must track attendance and participation using Verification Logs provide for them. They are to be initialed each time the participant exercises. At the end of a month, have the supervisor approve a monthly log by initialing it and sending it to the Workforce Wellness Coordinator [instructions for mailing or faxing are on the top of each roster]. Participation/activity records must be received within the first full workweek of the month.
- d. **ALL** participants are required to participate in a pre- and post fitness assessment in addition to attending a minimum of 4 classes of their choice on wellness subjects. Participants will receive guidance and instruction in physical fitness and in other health related areas during the six months. All participants are reminded that results do not occur overnight. A reasonable and steady exercise effort will produce results. While some muscle soreness may occur, participants are advised to stop exercise and report pain to fitness advisors. Some modifications may be required in their exercise programs.

3. Supervisor's Responsibilities

- a. Supervisors should encourage participation in the program.
- b. Supervisors will review and initial employee's monthly attendance rosters.
- c. Supervisors will maintain records to support the participant's involvement in the program. Once the Program coordinator has reviewed all papers, supervisors will receive appropriate information for their files. Each supervisor will be notified when an applicant is accepted into the program as well as of the start-end dates.

- d. Consistent with mission requirements, supervisors should allow duty time for employee's participation in training and exercise. If possible, allow participants to combine their exercise hour with either their lunch hour or morning or afternoon break. This time will enable the participant for "cool down" and maintenance of personal hygiene.
- e. Contact Wellness Coordinator Ginny Rappleyea with any questions or concerns E-mail or X23275.

4. Permitted Activities

- a. Each civilian participant is authorized 3 hours of excused administrative absences a week for six months to conduct his or her exercise program. Unused exercise hours may not be carried forward to subsequent weeks nor can these exercise times be used for any non-duty purpose. Exercise periods are official duty time and must occur on post. Misuse of this time as an infraction and would cause an individual to be subject to disciplinary actions.
- b. Participation is expected on-Post and must include an aerobic or cardiovascular fitness activity (e.g. brisk walking, jogging, bicycling, lap swimming, ect.). An aerobic activity uses large muscle groups usually rhythmically, and is maintained for a long period of time, such as 20-60 minutes for three to five times per week. Combined activities may be permitted such as walking on the treadmill for 20 minutes and weight/strength training for 20 minutes.
- c. Activities such as bowling, doubles tennis and golfing are RECREATIONAL activities and ARE NOT permitted activities.

FORT MONMOUTH WORKFORCE WELLNESS PROGRAM
(Please complete this form and return it with your packet)

EMPLOYEE & SUPERVISOR AGREEMENT

For

Workforce Wellness Program Participation

*Make a copy for your supervisor and return one copy to the Wellness Program Coordinator's Office/MWR Ginny Rappleyea, Physical Fitness Center, Bldg. 114, SELFFM-MWR-FA-L, Fort Monmouth, NJ 07703

Name of Employee _____

Unit/Directorate _____

Work Phone: _____ Fax number: _____

E-mail address:

Name of Supervisor: _____

AGREEMENT

1. We understand and agree that (employee name)

will be participating in the command-sponsored Workforce Wellness Program for 3 one-hour sessions each week for a total of 78 hours over a consecutive 6 month period beginning _____ and ending _____. We understand and agree that the specified exercise location will be the place of duty during authorized exercise periods, as follows. Exercise periods are designated on the following days of the week

_____ / _____ / _____

at the following time _____ to _____ and at the following location(s)

Activities such as bowling, doubles tennis and golfing are recreational activities and ARE NOT permitted activities.

2. We also understand and agree that:

NOTE: The following examples may be individually amended or deleted. The list is not necessarily all-inclusive.

*Exercise days, times, and/or locations may be periodically amended only with prior approval and notation of the supervisor, and amendment of this agreement.

*Unused exercise hours may not be carried forward to subsequent weeks.

*The program end date will not be extended to make up for exercise periods missed because of leave, temporary duty, or other reasons.

*Exercise periods may be combined with only one of the following: morning break, afternoon break, lunch period.

*No additional duty time is automatically authorized as part of this program for perexercise preparation (e.g. changing clothes) prior to exercise periods, or for personal hygiene or “cooling down” after exercise sessions.

*Specified exercise periods may not be used for any non-duty purpose. Any period or portion thereof not used in actual fitness training and exercise will be spent in the normal duty workplace accomplishing regular duties.

*Exercise periods are official duty time. Failure to appear, inappropriate use of exercise time, or misconduct during these periods would be considered as workplace infractions occurring during normal duty hours, and would be subject to the same disciplinary actions applied to other infractions.

*For the duration of the program, the employee will attend a minimum of four educational support classes/lectures of his/her choice.

Signature of Employee _____

Date _____

Signature of Supervisor _____

Date _____

FORT MONMOUTH Workforce Wellness Program

Physical Fitness Assessment Sheet

***Please have your physician fill out only medical information at the top of this page. The rest of it will be done at Fort Monmouth's Physical Fitness Center.

NAME : _____ AGE : _____

Please fill out the top of this page - STOP at "Fitness Component"

Resting Heart Rate (beats/min) _____

Resting Blood Pressure (mmHG) _____

Cholesterol (Please have your personal physician complete this part)

Total _____ HDL _____ LDL _____

Ratio _____ Triglycerides _____

Blood Glucose (Please have your personal physician complete this part) _____ mg/dl

| <u>Fitness Component</u> | Test | Raw Measures | Final |
|---------------------------------|-------------|---------------------|--------------|
| Body Composition | Impedance | _____ ohms | _____ % fat |
| | | Skin fold Calipers | |
| | | _____ % fat | |

| | | | |
|--|---------------|----------|--|
| | Triceps/chest | _____ mm | |
| | Hip/waist | _____ mm | |
| | Thigh | _____ mm | |

| | | | |
|------------------------|--------|-----------|-------------|
| Body Mass Index | Height | _____ in | _____ index |
| | Weight | _____ lbs | |

| | | | |
|---------------------------|---------------------|----------|-------------|
| Waist to Hip Ratio | Waist Circumference | _____ in | _____ ratio |
| | Hip Circumference | _____ in | |

| | | | |
|-----------------------|-------------|---------------------|--|
| Cardiovascular | Step Test | _____ pulse | |
| | Ergo meter | _____ ml/()2/kg/min | |
| | 1-mile walk | _____ time | |
| | | _____ pulse | |

| | | | |
|--------------------------|-------------|-----------|-------------|
| Muscular Strength | Chest Press | _____ lbs | _____ ratio |
| | Leg Press | _____ lbs | _____ ratio |

| | | | |
|---------------------------|----------------|------------|--|
| Muscular Endurance | 1 min. sit-up | _____ reps | |
| | 1 min. push-up | _____ reps | |

Flexibility

Sit and reach _____ in

Please fill in your name and phone number
List your long term 6 month goal and please
Return this sheet with your packet.

NAME _____

PHONE _____

**FORT MONMOUTH Workforce Wellness Program
GOAL SHEET**

- Set realistic goals! (lose weight, increase endurance, lose inches, ect.)
 - Use this sheet to record accomplishments

LONG TERM 6 MONTH GOAL: _____

| <u>Month</u> | <u>Goal 1</u> | <u>Goal 2</u> | <u>Goal 3</u> | <u>Goal 4</u> | <u>Goal 5</u> |
|--------------|---------------|---------------|---------------|---------------|---------------|
|--------------|---------------|---------------|---------------|---------------|---------------|

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

FORT MONMOUTH Workforce Wellness Program

Please fill this form out, make a copy for yourself as a reminder to hand in your activity Rosters and send the original back with the rest of the paperwork.

DATABASE

LAST NAME _____

FIRST NAME _____

DIRECTORATE/Mailing Symbol _____

SUPERVISOR'S NAME _____

SUPERVISOR'S PHONE _____

REGISTRANT'S PHONE _____

Activity Rosters Required*

Must be turned in MUST be returned completed to the Wellness Coordinator's Office.

Applicant's Health History _____

Health History/Risk Factors _____

Symptom Inventory Checklist _____

Physician's Approval _____

Release of Liability _____

Targeting Fitness/Informed Consent _____

Employee-supervisor Agreement _____

Physical Fitness Assessment Sheet _____

Goal Sheet _____

Database (this sheet. Please make a copy for yourself and turn in the original.) _____

