

Medical Release Form

Patient's Name

has my permission to participate in
the Parkinson Exercise Class

Listed below are problems that may
affect this patient's performance in class.

Dx/Med Condition

Limitations or Precautions

Physician's

Signature

Date

Please return this form directly to your
patient.

Functional Fitness

In this class you will.....

☆ Participate in exercises,
activities and improve your
function and mobility.

☆ Meet other people with similar
problems and develop new
relationships.

☆ Learn more about Parkinson's
disease.

☆ Gain understanding that may
help you have new experiences
and improve the quality of your
life.

☆ Have fun.

FIT 'N FUN



***Exercise Classes
For People with
Parkinson's Disease***

Sponsored by

***St. Louis Chapter of
American Parkinson Disease Association***

Exercise Classes

Clayton

Barnes Jewish Extended Care
401 Corporate Park
Wednesday, 1:30 -2:30 P.M.
Sue Tucker, OT @ (314) 289-4325
Mike Scheller, OT (314) 289-4202
Optional Class Friday 1:30-2:30 P.M. \$20

West County

St. John's Mercy Rehabilitation Hospital
14561 N. Outer 40
Tuesday 1:00-2:00 P.M.
Deb Luetkemeyer, PT @ (314) 881-4200

St. Luke's Hospital
232 S. Woods Mill Rd.
Tuesday 10:30-11:30 A.M.
Patty Seeling, PT, @ (314)-205-6934

St. Peters

Barnes-Jewish St. Peters Hospital
Healthwise Center
6 Jungermann Circle
Every Tuesday 11:00-Noon
Except 1st Tuesday
Holly Leigh, PT @ (636) 916-9650

South St. Louis

Garden Villas South
13457 Tesson Ferry Rd.
Monday 11:30 A.M.-12:30 P.M.
Sue Tucker, OT @ (314) 289-4325
Mike Scheller, OT @ (314) 289-4202

North St. Louis

Garden Villas North
4505 Parker Road
Tuesday/Thursday 10:00-11:00 A.M.
Shannon Crouch, PTA
314-355-6100

**Regular Sessions Are Offered
At No Charge**

Classes are a service provided by:

St. Louis Chapter of the
American Parkinson Disease Association
Campus Box 8111
660 South Euclid Ave.
St. Louis, MO 63110
Phone: (314) 362-3299
Fax: (314) 747-1601

www.stlapda.org

Registration Form

Please complete this side of the Registration Form.

Have your physician complete the reverse side.

Bring this to class your first day!

Name _____

Address _____

Phone _____

Date _____ of
Birth _____

Person to notify in case of an emergency:

Phone _____

P h y s i c i a n ' s
Name _____

P h y s i c i a n ' s
Phone _____

Please list any problems that may affect
your ability to exercise:

