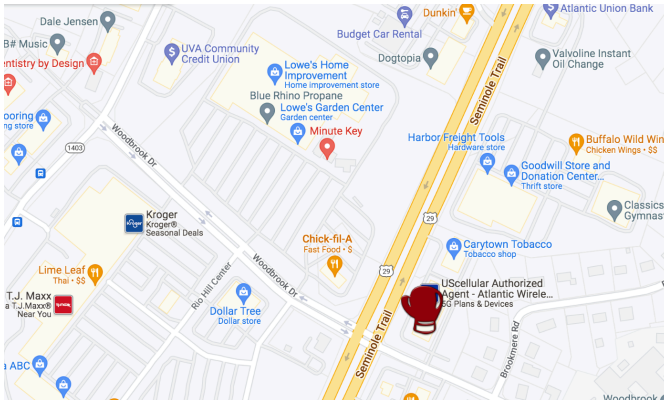
Quick Info Guide

What Do I Need To Do?

Step 1: Complete and submit the **Intake Forms**
Step 2: Have your Doctor complete the **Physician Medical Release Form** (must be signed and returned prior to assessment)
Step 3: Schedule an assessment with Coach Sarah
Step 4: Fight Back Against Parkinson's!!

Where Are We Located?

1885 Seminole Trail, Suite 101
Charlottesville, VA, 22901



How Much Will This Cost Me?

Assessment (a one time cost): $65
Gloves + Wraps from Sports Store: Varies in Cost
Special Package (Assessment + Boxing Gloves + Gel Wraps): $100
Monthly Unlimited Membership (unlimited classes per month): $160
Drop-In Rate (per class; charged at the end of the month): $25

Current Rock Steady Boxing Charlottesville Classes Offered at The PARC

Piedmont Punchers PD Level 1	Blue Ridge Boxers PD Level 2	Wahoo Warriors PD Level 3/4	Rivanna Rumblers PD Level 3/4 Cognitive
Monday - 4:45pm	Monday - 3:30pm		
Tuesday - 8:30am	Tuesday - 10:00am	Tuesday - 3:30pm	Tuesday - 11:30am
Wednesday - 10:00am	Wednesday - 3:30pm	Wednesday - 11:30am	
Wednesday - 4:45pm			
Thursday - 8:30am	Thursday - 10:00am	Thursday - 3:30pm	Thursday - 11:30am
Friday - 10:00am		Friday - 11:30am	
Saturday - 10:00am*	Saturday - 11:30am		

indicates class is full
----- More classes to become available as needed -----

Sarah's cell (434) 953-8583 **info@the-parc.org**

updated 9/1/2025

RETURN ALL FORMS TO
The Parkinson's Activity and Resource Center
C/O Sarah Lincoln
1885 Seminole Trail, Suite 101, Charlottesville, VA 22901
Phone - (434) 953-8583 Email - info@the-parc.org

Member Information

Welcome to The Parkinson's Activity and Resource Center! We are pleased to welcome you into our program.

To begin, please complete the following documents:

1. Member Information Form (page 1)
2. Notes and Questions for Administrator (page 2)
3. Personal Waiver and Release of Liability (page 3)
4. Physician Medical Release Form (page 4)

Date ____/____/____

Name _____ DOB _____/_____/_____

Address _____

City _____ Zip Code _____

Home phone _____Cell phone _____

Business Phone _____Email _____

How did you hear about The PARC/ Rock Steady Boxing Charlottesville (circle)?

Referral / Media / Website / Other_____

Emergency Contact Information

Name _____

Relationship to applicant_____

Address _____

City _____ Zip Code _____

Home phone _____Cell phone _____

Email _____

PARC
THE PARKINSON'S
ACTIVITY AND RESOURCE CENTER

ROCK STEADY BOXING
CHARLOTTESVILLE

Notes and questions for test administrator

What symptoms of Parkinson's are you experiencing in your daily life?

_____

_____

Have you been diagnosed with any other medical problems we should be aware of?

_____

_____

What do you wish to gain from joining The Parkinson's Activity and Resource Center?

_____

_____

Do you have questions or concerns about the program before we get started?

Additional administrator notes: _____

_____

_____

(Administrator to explain Media Release during assessment)

Media Release

I _____ (member name) allow The Parkinson's Activity and Resource Center to publish or broadcast my image/likeness and/or name for promotional purposes associated with The Parkinson's Activity and Resource Center.

Signature _____Date _____

PARC
THE PARKINSON'S
ACTIVITY AND RESOURCE CENTER

ROCK STEADY BOXING
CHARLOTTESVILLE

Waiver and Release of Liability

The Parkinson's Activity and Resource Center. (hereinafter, "The PARC"):

1. I understand the nature of The Parkinson's Activity and Resource Center's activities, and my physical condition and capabilities, and I believe that I am physically capable of participating in such activity. I further acknowledge that I am aware that the activity may be conducted in facilities open to the public or members of the public and/or employees of another corporate entity or entities, during the activity. I further agree and warrant that any time, if I believe any condition to be unsafe, I reserve the right, without penalty, financial or otherwise, to immediately discontinue further participation in the activity and bring such condition to the attention of the management of The PARC.
2. **I FULLY UNDERSTAND** that (a) the activities of The PARC involve risks and dangers of **SERIOUS BODILY INJURY**, including permanent disability, paralysis and death ("Risks"); (b) these Risks and dangers may be caused by me or by the actions or inactions of others participating in the activity, the conditions under which the activity takes place, or **THE NEGLIGENCE OF THE "RELEASEES" NAMES BELOW**; (c) there may be other risks and social and economic losses either known to me or not readily foreseeable at this time, and **I FULLY ACCEPT AND ASSUME ALL SUCH RISKS AND ALL RESPONSIBILITY FOR LOSSES, COSTS, AND DAMAGES** incurred as a result of my participation in these activities.
3. **I HEREBY RELEASE, DISCHARGE, COVENANT NOT TO SUE, AND AGREE TO INDEMNIFY AND SAVE AND HOLD HARMLESS THE PARC**, its clubs and their respective administrators, directors, agents, officers, volunteers, and employees, other participants, any sponsors, advertisers, and if applicable, owners and lessors of premises on which the activities take place (each considered one of the "Releasees" herein) from all liability, claims, demands, losses, or damages on my account caused or alleged to be caused in whole or in part by the negligence of the "Releasees" or otherwise, including negligent rescue operations and further agree that if, despite this release, I or anyone on my behalf makes a claim against any of the Releasees, I will be responsible for the payment to any or all of the releasees harmed by such assertion of a waived claim , or any expenses arising from my assertion of waived claims or causes of action, including but not limited to reasonable attorney fees and court costs.
4. I certify that I have had no injuries to my hands, whether fractures, broken bones, or otherwise, within the three months preceding the dates of completion of this entry form, and have no injuries to the head, concussion, headaches or fainting spells, and should I experience any of these injuries and/or conditions in the future, I will immediately notify the officials of these events and/or conditions, and immediately cease my participation in said events and activities.
5. I hereby further agree that this agreement may not be modified orally, and a waiver of any provision shall not be construed as a modification of any other provision herein or as consent to any subsequent waiver or modification. Every term and provision of this agreement is intended to be severable, if any one or more provision is found to be unenforceable or invalid, said provision shall not affect the other terms and provision, which shall remain binding and enforceable.

_____ Date ____/____/____

Printed Name of Applicant

_____

Signature of Applicant

Physician Medical Release Form

THE PARKINSON'S ACTIVITY AND RESOURCE CENTER

ROCK STEADY BOXING CHARLOTTESVILLE

TO BE COMPLETED BY YOUR PRIMARY CARE PROVIDER OR NEUROLOGIST

Date: _____/_____/_____

Doctor's Name:_____

Your patient, _____, DOB _____/_____/_____wishes to participate in the Rock Steady Boxing Charlottesville (NON-CONTACT) exercise program. The activity will involve cardiovascular training (jumping rope, running, punching heavy bags), flexibility instruction (stretching, getting up and down on the floor), resistance training and core strengthening techniques. Participants can attend up to six classes per week that are sixty minutes in duration. Participants can reach up to 90 percent of their maximum heart rate.

PHYSICIAN'S RECOMMENDATION :

☐ I am not aware of any restrictions to participate in this exercise program.

☐ I believe the patient can participate but would urge caution (please explain):

_____

☐ Patient should not engage in the following activities:

_____

If your patient is taking medications that will affect their heart rate response to exercise, please indicate the manner of the effect (raises, lowers or has no effect on heart rate response during exercise:

Type of medication _____ Effect _____

Type of medication _____ Effect _____

Type of medication _____ Effect _____

PHYSICIAN COMPLETES

_____ (patient's name) has my approval to begin the Rock Steady Boxing Charlottesville exercise program with the recommendations or restrictions stated above.

Printed name _____ Phone _____

Signature _____ Email _____

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