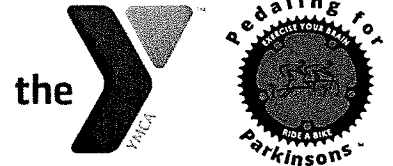
Pedaling For Parkinson's Participant Medical Screening Questionnaire
(to be completed by the Participant)



Name: ______________________ Male □ Female □
Diagnosis: ______________________
Date of Diagnosis: ______________________

Prescreening Questions:

Yes □ **No** □ Have you taken any heart medications?

Yes □ **No** □ Do you take blood pressure medication?

Yes □ **No** □ Have you ever had a heart attack?

Yes □ **No** □ Are you a diabetic or take medicine to control blood sugar?

Yes □ **No** □ Have you ever had heart surgery?

Yes □ **No** □ Have you ever had heart failure?

Yes □ **No** □ Is your blood cholesterol >240 mg/dl?

Yes □ **No** □ Females: Have you had a hysterectomy or are you postmenopausal?

Yes □ **No** □ Have you ever had pacemaker/implantable cardiac defibrillator/rhythm disturbance?

Yes □ **No** □ Have you experienced dizziness, fainting or blackouts?

Yes □ **No** □ Have you ever had coronary angioplasty?

Yes □ **No** □ Have you ever had cardiac catheterization?

Yes □ **No** □ Have you ever had heart valve disease?

Yes □ **No** □ Do you smoke?

Yes □ **No** □ Have you ever had congenital heart disease?

Yes □ **No** □ Have you had a close blood relative who had a heart attack before age 55(father/mother) or 65 (brother/sister)

Yes □ **No** □ Have you experienced unreasonable breathlessness?

Yes □ **No** □ Have you ever experienced chest discomfort with exertion?

Yes □ **No** □ Do you have musculoskeletal problems that would prevent you from exercising?

Yes □ **No** □ Are you physically inactive, exercising less than 30 minutes per day/3 days per week?

Yes □ **No** □ Do you have concerns about the safety of exercise?

______________________ ______________
Participant Signature Date

RELEASE AND WAIVER OF LEGAL LIABILITY

Pedaling for Parkinson's™

(to be completed by participant)

Name of Participant: ______________________________ **Phone:**____________________________

Emergency Contact Name: __________________________ **Phone:**____________________________

THIS IS YOUR RELEASE AND WAIVER OF LIABILITY (the "Release"). You release the Capital District YMCA, its officers, directors, board members, employees, volunteers, agents, independent contractors, other participants and/or others acting on its behalf (collectively, "YMCA"). **You agree that this Release is effective immediately.**

1) ASSUMPTION OF RISK: I expressly and specifically assume any and all risk of injury, illness, death, or property damage resulting from my participation at the YMCA. **You assume the risks:** I understand that the YMCA activities are strenuous and dangerous and that it is impossible to predict everything that may occur. I understand that the activity should be engaged in only by persons in good health. I understand that I should consult a physician before engaging in any physical activity. **Once you sign, you are saying that you understand the risks involved and accept all of the risks.** You acknowledge that the YMCA is a charitable organization and that you are a beneficiary of the YMCA.

2) GENERAL RELEASE, INDEMNIFICATION AND HOLD HARMLESS: I hereby agree for myself and/or my minor child(ren) and our respective heirs, assigns and legal representatives, to indemnify, defend and hold YMCA and its officers, directors, board members, employees, volunteers, agents, independent contractors and other participants ("Releasees") harmless from **ANY AND ALL CLAIMS AND CAUSES OF ACTION OF ANY NATURE, INCLUDING NEGLIGENCE for any and all personal and/or bodily injury or illness, including death, which may occur to myself or my minor child or which may be aggravated during or by any activity in which I have decided to allow myself or my minor child to participate.** I further expressly understand and agree the foregoing indemnity, release and waiver is intended to be as broad and inclusive as permitted by the law of the State of New York and that any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full force and effect.

I HAVE READ THE ABOVE WARNING, WAIVER, AND RELEASE AND UNDERSTAND THAT I GIVE UP SUBSTANTIAL RIGHTS FOR MYSELF AND/OR MY MINOR CHILD BY SIGNING IT, AND KNOWING THIS, SIGN IT VOLUNTARILY. I AGREE TO PARTICIPATE AND/OR ALLOW MY MINOR CHILD TO PARTICIPATE KNOWING THE RISKS AND CONDITIONS INVOLVED AND DO SO ENTIRELY OF MY OWN FREE WILL. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIAN AS EVIDENCED BY THEIR SIGNATURES BELOW. I ACCEPT:

______________________________ ______________

Applicant/Participant Signature Date

______________________________ ______________

Applicant/Participant's Spouse Date

Medical Clearance Form *(to be completed by doctor)*

Physicians' Name:______________________________ Patient Name:______________________________

Physician's Phone:______________________________ Patient DOB:______________________________

Physician's Fax:______________________________ Date:______________________________

Dear Doctor ______________________________,

Your patient has requested to participate **in Pedaling for Parkinson's™**. The Pedaling for Parkinson's™ program is based on research indicating that **forced exercise on a bicycle** can reduce symptoms of **Parkinson's**. Research shows participants who ride three days a week over eight weeks have shown improvement in their **Parkinson's**-related symptoms by as much as 35%. A typical Pedaling for Parkinson's class includes a certified instructor and class size ranges anywhere from 3 – 20 participants. Each one-hour exercise session consists of a 10-minute warm-up, a 40 minutes main exercise set and a 10-minute cool-down. During the main exercise set, the pedaling rate must be maintained between 80-90 RPMs and the participant's heart rate must be kept within the target heart rate zone (60-85% of the participant's max heart rate).

By completing the form below, you are not assuming any responsibility for our administration of the exercise program. If you know of any medical or other reasons why participation in the **Pedaling for Parkinson's**™ program would be unwise for your patient, please indicate so on this form.

If you have any questions regarding the **Pedaling for Parkinson's**™ program, please call the program coordinator.

Program Coordinator: Phone (518)
Return email:

Physicians Report

Yes □ **No** □ Patient has a clinical diagnosis of idiopathic PD
Yes □ **No** □ Patient is graded at Hoehn and Yahr stage I, II, or III when off medication
Yes □ **No** □ Dementia score is less than 116 on the Mattis Dementia Rating Scale
Yes □ **No** □ Patient has other medical or musculoskeletal conditions that would exclude them from this program
Yes □ **No** □ Patient has no other significant clinical disease that would increase the risk of exercise – related complications (e.g. cardiac or pulmonary disease, hypertension or stroke) **If NO, please explain below**

____

________Not cleared to exercise at this time
________Cleared to exercise with no restrictions
________Cleared to exercise with the following restrictions and/or recommendations

____
____

Physicians Name: ______________________________

Physicians Signature: ______________________________ Date: ____________