Neuromotor Wellness 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
Neuromotor Wellness
(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 the Capital District YMCA's **Neuromotor Wellness. Neuromotor Wellness** is research-based exercise program specifically for thoe diagnosed with muscular degeneration challenges including but not limited to Parkinson's, Multiple Sclerosis, ALS, stroke recovery, and muscle injury. This class can assist in slowing disease progression, restoring motor function, and increasing longevity and quality of life. This 45 minutes class will include slow cardiovascular and functional movements, balance and coordination exercises, strengthening exercises, and facial and verbal exercises.

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 **Neuromotor Wellness** program would be unwise for your patient, please indicate so on this form.

If you have any questions regarding the **Neuromotor Wellness** program, please call the program coordinator.

Program Coordinator: Phone (518)
Return email:

Physicians Report

_____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: _____