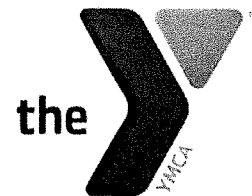


**Neuromotor Wellness Participant Medical Screening Questionnaire**  
(to be completed by the Participant)



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 those 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:

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**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

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Physicians Name: \_\_\_\_\_

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_