Spring 2020 P.R.I.D.E.4Adults Registration Form
P*hysical activity and* **R***ecreation for* **I***ndividuals with* **D***isabilities in the* **E***au Claire area*

Medical Information and Physician Release

Participant's Name _____ Age _____

Address _____

Type of Disability _____

Age of Onset _____ Approximate date of last medical exam _____

Severity of Condition: Mild _____ Moderate _____ Severe _____

Functional Capacity of Participant:

_____ Unrestricted No restriction need to be placed on the participant relative to intensity or type of activity.

_____ Restricted Participant's condition is such that the intensity and type of the activity need to be limited.

_____Mild Restriction Ordinary physical activity need not be restricted but unusually vigorous efforts need to be avoided.

_____Moderate Restriction Ordinary physical activity needs to be moderately restricted and sustained strenuous efforts need to be avoided.

_____ Maximal Restriction Ordinary physical activity needs to be markedly restricted.

Is the participant taking any medications? (yes or no)
If yes, please list. _____
_____

Dr's Signature: _____ Date: _____

Dr's Name (please print) & phone number: _____

This page and the next are to be filled out by participant

P.R.I.D.E.4ADULTS
Emergency Treatment Release Form

Participant's Name_____

Home Address _____
_____
_____

Home Phone _____ Cell Phone _____

Doctor's Name _____

Doctor's Phone _____

Hospital at which you're usually treated _____

Emergency Contact _____

Contact's Day Phone Number _____ Contact's Cell Phone _____

In the event that I should, for any reason, require minor medical care or emergency medical treatment during the course of the P.R.I.D.E. for Adults program, I consent to receive such assistance by appropriate staff or medical personnel. I will not hold the university or personnel involved in the program legally responsible for injury or accidents which may occur. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment.

_____ _____
Participant's Signature Date

Video/Photo Authorization

I, the undersigned, hereby authorize the use of a video taken by Dr. Marquell Johnson, director of the P.R.I.D.E. 4ADULTS Program, to be used to help train student volunteers who work in our program. It will be used primarily to teach students and volunteers about movement characteristics and exercise techniques of/for individuals with disabilities.

_____ _____
Signature of Participant Date

_____
Printed Name

P.R.I.D.E.4ADULTS
Participant Consent Form

I, on my own behalf, make the following representations and releases:

1. I must a have a medical doctor's referral in order to participate in the program.

2. I understand that an assessment will be needed upon entering the program to determine my present level of function and muscle strength. Such information will be used to plan and implement an individualized exercise program. Periodic reassessment may also be scheduled to evaluate progress.

3. I realize that any devices, equipment, etc. needed to participate in the program (other than those typically provided in the program) must be supplied by the individual.

4. I will not hold the P.R.I.D.E. for ADULTS Program, the University of Wisconsin-Eau Claire, the L.E. Phillips Senior Center liable for any accident or injury incurred while participating in said program. I understand that the cost of the coverage for medical expenses for accident or injury is the participant's responsibility.

5. I realize that medical information and related data may be shared with supervisors and interns within the program for educational purposes. The directors, agents, employees or students of the University of Wisconsin – Eau Claire are hereby released, acquitted, and discharged from any claims for damage or suit by reason of injury, illness or damage to person or property during the course of the P.R.I.D.E. for ADULTS Program, including transportation to and from the program.

I have read and fully understand the provisions of the above consent from and agree to its terms and conditions.

Participant's/Legal Guardian's Signature_____

Date _____

Please return registration form and payment in stamped envelope or to:
Department of Kinesiology, attn. Dr. Marquell Johnson
UW-Eau Claire
McPhee Physical Education Center, 221
Eau Claire, WI 54702

For Office Use Only	
Received	Medical Form