



RELEASE AND WAIVER OF LEGAL LIABILITY

Parkinson's Center Membership

(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.**

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

Date



Parkinson's Center 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



Parkinson's Disease Exercise Program: Assessment Form

To be completed at: Initial Start

Participant Name: _____

Date: _____ DOB: _____ Gender: Male Female Other

Diagnosis & Year: _____ Current Parkinson's Stage (if known): _____

SECTION 1: PHYSICAL HEALTH & FUNCTIONAL STATUS

Over the past 2 weeks, how much difficulty have you had with the following activities?

Activity	No Difficulty	Some Difficulty	Great Difficulty	Unable to Do
Walking short distances (under 50 feet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking longer distances (more than 500 feet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting out of a chair without use of armrests/or help of a caregiver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintaining Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting dressed without help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using hands for fine motor tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you currently use any of the following? Cane Walker Wheelchair None

How many times have you fallen in the past 6 months? _____

Did any falls result in injury? Yes No

Which of the following do you experience regularly?

Tremor Muscle stiffness Slowness of movement Freezing Fatigue Dizziness Sleep difficulty Difficulty swallowing Constipation

Do you currently exercise? Yes No

If yes, type/frequency: _____

SECTION 2: MENTAL & EMOTIONAL HEALTH

In the past two weeks, how often have you felt the following? (0 = Not at all, 1 = Several days, 2 = More than half the days, 3 = Nearly every day)

Symptom	0	1	2	3
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling anxious, nervous, or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling/staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling socially isolated or lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you feel Parkinson's has affected your confidence or self-esteem? Not at all Somewhat Significantly

Do you participate in a support group or receive counseling? Yes No

If yes, describe: _____

Do you live alone or with a care partner? If you live with a care partner, please describe the activities or tasks they assist you with

SECTION 3: GOALS & EXPECTATIONS

What do you hope to achieve through this exercise program? (Check all that apply)

- Improve mobility
- Increase strength or flexibility
- Reduce tremors or stiffness
- Prevent falls
- Improve mental well-being
- Social connection
- Other: _____

In 6 months, I would like to be able to: _____

Do you have any concerns about starting or continuing exercise? No Yes – Please explain:



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 join the Capital District YMCA's Parkinson Center YMCA. The Parkinson's Center offers specialized group exercise and wellness classes designed to support individuals living with Parkinson's disease and other movement disorders. Programs include Pedaling for Parkinson's™, Tai chi, Yoga, Boxing, Dance for PD®, and other research-based activities that promote strength, balance, flexibility, and overall quality of life. Participation may involve low to moderate physical activity tailored to each individual's abilities. Medical clearance is requested to ensure safe engagement in these programs.

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

If you have any questions regarding the Parkinson's Center YMCA programs, please contact the program coordinator.

Program Coordinator: Toni Carroll | 518.818.1190

Return email: tcarroll@cdymca.org

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: _____