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 Signature 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

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: Kimmarie Uhalde | 518.992.2282
Return email: kuhalde@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

If your patient has another diagnosis other than Parkinson's, state here: _____

Physicians Name: _____

Physicians Signature: _____ Date: _____

Parkinson's Disease Exercise Program: Assessment Form

To be completed at: ☐Initial Start ☐6-Month Check-in ☐1-Year Follow-Up

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)	☐	☐	☐	☐
Walking longer distances (more than 500 feet)	☐	☐	☐	☐
Getting out of a chair without use of armrests/or help of a caregiver	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐
Maintaining Balance	☐	☐	☐	☐
Getting dressed without help	☐	☐	☐	☐
Using hands for fine motor tasks	☐	☐	☐	☐

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	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Feeling anxious, nervous, or on edge	☐	☐	☐	☐
Trouble falling/staying asleep	☐	☐	☐	☐
Trouble concentrating	☐	☐	☐	☐
Feeling socially isolated or lonely	☐	☐	☐	☐

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:
_____