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

CAPITAL DISTRICT YMCA

Parkinson's Center Participant Medical Screening Questionnaire

(To be completed by the participant)

Name: _____ **Male** ☐ **Female** ☐

Parkinson's/Movement Disorder Diagnosis: _____

Date of Diagnosis: _____

Prescreening Questions

Please check **Yes (Y)** or **No (N)** for each question.

Question	**Y**	**N**
Have you taken any heart medications?	☐	☐
Have you ever had a heart attack or stroke?	☐	☐
Are you diabetic or take medicine to control blood sugar?	☐	☐
Have you ever had heart failure?	☐	☐
Have you ever had a pacemaker, implantable cardiac defibrillator, or rhythm disturbance?	☐	☐
Have you experienced dizziness, fainting, or blackouts?	☐	☐
Have you experienced unreasonable breathlessness?	☐	☐
Have you ever experienced chest discomfort with exertion?	☐	☐

Musculoskeletal and Other Health Information

Do you have musculoskeletal problems that would prevent you from exercising?

☐ Yes ☐ No

List any orthopedic surgeries: _____

_____

Have you ever been diagnosed with cancer or had any related surgeries?

☐ Yes ☐ No

If yes, please specify: _____

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?

☐ Yes ☐ No

If there is anything else that may impact your ability to exercise, please specify:

Participant Signature: _____

Date: _____

Medical Clearance Form

(To be completed by physician)

Physician's Name: _____

Patient Name: _____

Physician's Phone: _____

Patient DOB: _____

Physician's Fax: _____

Patient Phone: _____

Date: _____

Dear Dr. _____,

Your patient has requested to join the **Capital District YMCA's Parkinson's Center**. 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 Beyond Parkinson's**, 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 responsibility for the administration of these exercise programs. If there are any medical or other reasons why participation would be unwise, please indicate so below.

For questions regarding the Parkinson's Center YMCA programs, please contact:
Wellness Coordinator: Kimmarie Uhalde
Fax: 518.992.2850 **Phone:** 518.992.2282 **Email:** kuhalde@cdymca.org

Physician's 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 the patient has a diagnosis other than Parkinson's, please specify:

Physician's Name: _____

Physician's Signature: _____

Date: _____