Office Use Only
Date Received:

Adult Fitness Program

Participant Enrollment Form

To Participant and/or Legal Guardian: To safely participate in the Adult Fitness Program at UW-La Crosse, please complete this form as accurately as possible. All information is necessary to maximize safety and will be kept confidential. Please use the back of the page if you need more space. Incomplete information may delay enrollment into the program.

Participant's name_____ Gender: ☐M ☐F

Address _____

Age_____ Date of Birth_____

Parent/Guardian name _____ Relationship to Participant_____

Parent/Guardian address_____

Parent/Guardian phone_____

Parent/Guardian e-mail_____

Emergency contact (In case parent(s)/guardian(s) cannot be reached):

Name_____ Phone_____

Relationship to participant _____

Physician's name_____ Phone_____

Physician's address_____

Physical therapist_____ Phone_____

Occupational therapist_____ Phone_____

Primary disability of participant _____

Secondary disability _____

Relevant medical concerns _____

_____

Parts of body affected (describe)_____

_____

Body movements that should be avoided (describe) _____

_____

Is the participant ambulatory? YES NO

Does the participant use any braces, wheelchair or other special equipment? If so, what?

_____

Medications Taken **What For** **Side Effects**

_____

_____

_____

Does the participant have allergies? (**including latex**) YES NO If yes, please list_____

_____

How are allergies controlled?

_____

Does the participant have seizures? YES NO If yes, type(s) of seizure and how long they usually last

_____

How are the seizures controlled? _____

Controlled by medication? (please list) _____

How often do they occur? _____ Date of last seizure_____

Please answer the following with CA, MODA, MINA, or I.

CA = complete assistance
MODA = moderate assistance
MINA = minimal assistance
I = independent (can perform task alone with supervision)

Dressing in a locker room	_____	Entering pool	_____
Undressing in a locker room	_____	Exiting Pool	_____
Swimming in pool	_____	Toileting	_____
Walking upstairs	_____	Walking Downstairs	_____
Mobility in hallway	_____		

Comments about needed physical assistance needed for daily living skills_____

_____

_____

Verbal? _____ Nonverbal? _____ How does the participant communicate? (describe)

_____

Physical activity currently involved in (describe) _____

_____

Has the participant been swimming or involved in any structured swim lessons? _____

If so, where and when?

_____

What is his/her swimming level? _____Is the participant afraid of the water? _____

Does the participant need special equipment for swimming? (ear plugs, goggles, cap)? (Please note you will need to provide these)_____

What kind(s) of motor activities, sports, and/or recreational activities does the participant like to engage in?

_____

_____

General Behavioral Characteristics (check those applicable)

Self-stimulatory ____ Withdrawn _____ Self-abusive _____ Amiable_____
Generally calm _____ Easily frustrated _____ Aggressive _____
Subject to physical outbursts _____

Briefly describe the participant's personality and behaviors: _____

_____

Does the participant have any behavioral issues? YES NO If yes, please describe.

_____

How are these issues best dealt with?

_____

_____

Do you have any ideas that may be helpful when interacting with you (the participant)? _____

_____

Please add any other important information that would be helpful to maximize safety and create a positive physical activity/physical fitness experience for you (the participant) _____

_____

Please indicate the session time you prefer by ranking them as your 1st 2nd and 3rd choice. All sessions meet on Tuesdays and Thursdays. We do not guarantee all preferences.

_____ 1:00 – 2:00 PM

_____ 2:00 – 3:00 PM

_____ 3:00 – 4:00 PM

Means of Transportation _____ Phone _____

Briefly state your anticipated goals for the program _____

_____

Center on Disability Health & Adapted Physical Activity
108 Mitchell Hall; 1725 State St
La Crosse, WI 54601
Office Phone: 608-785-8690
scoron@uwlax.edu

Adult Fitness Program
Emergency Release Form

Complete Section 1 if the participant fully understands the intent of this emergency release form. Please Complete Section 2 if the participant does not fully understand the intent of this emergency release form. Section 3 must be completed for all participants.

SECTION 1 Participant Signature

I, _____ the participant, give permission to receive emergency medical care in case of injury that may occur during the Adult Fitness Program. . I agree to defend, hold harmless, indemnify and release the Board of Regents of the University of Wisconsin System, the University of Wisconsin-La Crosse, and their officers, employees, agents, and volunteers, from and against any and all claims, demands, actions, or causes of action of any sort on account of damage to personal property, or personal injury, or death which may result from participation in the above-listed program.

_____ Date_____

Participant Signature

_____ Date _____

Witness Signature

SECTION 2 Legal Guardian Signature

Name of Participant (please print) _____

As legal guardian/parent, I give permission for the above-named individual to receive emergency medical care in case of injury that may occur during the Adult Fitness Program. I agree to defend, hold harmless, indemnify and release the Board of Regents of the University of Wisconsin System, the University of Wisconsin-La Crosse, and their officers, employees, agents, and volunteers, from and against any and all claims, demands, actions, or causes of action of any sort on account of damage to personal property, or personal injury, or death which may result from participation in the above-listed program.

_____ _____ _____

Parent or Legal Guardian Signature Date

SECTION 3 (All Must Complete this Section)

In the event of an emergency situation, the participant is to be taken to the:

_____ Emergency Room.
(Hospital/Clinic Name)

The participant's doctor is _____ phone _____

Address _____

If I cannot be reached, please contact:

Name _____Phone _____

Address _____

Relationship to participant _____

Name of Individual providing information on this form _____

Phone_____ Email_____

Date Completed _____

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UNIVERSITY OF WISCONSIN LA CROSSE UWL

Photo and Video/Testimonial Release Form

Copy and reuse form as needed

I/We hereby confer upon the University of Wisconsin-La Crosse, the University of Wisconsin-La Crosse Alumni Association and the University of Wisconsin-La Crosse Foundation the unrestricted and irrevocable right and permission with respect to the photographs and/or video taken of me or my children or in which we may be included with others:

a) To use, reuse, publish and republish the same intact or in part, separately or in conjunction with other photography, in any medium now and hereafter known, and for any purpose whatsoever (including illustration, promotions, advertising and trade) and;

b) To use my name and any testimonial I have provided to the university in connection therewith if UWL so decides.

I/We hereby release and discharge the photographer and/or videographer and the University of Wisconsin-La Crosse, the University of Wisconsin- La Crosse Alumni Association and the University of Wisconsin-La Crosse Foundation, from all and any claims and demands ensuing from on or in connection with the use of the photographs including any and all claims for libel and invasion of privacy.
I/We have read the foregoing and fully understand the contents hereof.

_____ _____

(Participant or Parent/Guardian signature) Phone Number (Date)

When securing releases from multiple subjects it is acceptable to use one release form signed by all relevant persons. You may use the back of this form for additional signatures.

PHOTOGRAPHY AND VIDEOGRAPHY RELEASE

I have read the foregoing and fully understand the contents hereof. I represent that I am the (parent/guardian) of the below named subjects. I hereby consent to the foregoing on his/her behalf.

Name of Participant_____

_____ _____

(Parent or Guardian Name) (Parent or Guardian Signature)

Address_____

City _____ State_____Zip_____

Phone _____ Email _____

_____ _____

(Witness Name and Signature) (Date)

For office use: Photo and Video/Testimonial used for_____

Photographer/Videographer _____

Participant: Please forward to the appropriate physician to complete

Physician: Please complete the Medical Information Form and send it to the address below.

TO: _____ (physician) Date _____

FROM: Brock McMullen, Ph.D., Director, Center on Disability Health

RE: Request for Medical Information on _____ (participant)

Attached is a Medical Information Form for the individual identified above who is seeking enrollment (or is currently enrolled) in the Adult Physical Fitness Program which has the following objectives:

1. To develop and maintain a functional exercise program upon a recommendation of medical personnel
2. To provide a program for the development of muscular and cardiovascular fitness and
3. To provide an environment for social interaction, and, if needed, enhance the skills of the individual for an active role in community settings.

Below you will find the signed Authorization for Release of Information giving permission for you to release appropriate medical information. Please scan and email or mail to return the form. Should you have any questions regarding this request, or the signed permission statement below, please contact me. Thank you for assisting.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Prospective Participant _____ Date of Birth _____

Name of Physician _____

I authorize _____ to release medical history and/or diagnostic information to include any physical therapy or occupational therapy information to the Center on Disability Health & Adapted Physical Activity. The purpose of this disclosure is to assist the staff of the Center in developing an individualized adult physical fitness program for the above-named participant.

_____ Initial Request _____medical update

_____ Date _____

Signature of Participant or Parent/Guardian

Center on Disability Health & Adapted Physical Activity
108 Mitchell Hall; 1725 State Street, La Crosse, WI 54601
Office Phone: 608-785-8690

Center on Disability Health & Adapted Physical Activity
Medical Information Form

General Information

Prospective Participant's name_____Age _____Date of Birth_____

Address_____

Date of Last Exam _____ Gender M F Height _____ Weight _____

Disability (primary/secondary) and/or other impairment (s) _____

_____

Describe physical/motor limitiation(s) _____

_____

Severity of the condition: _____ Chronic _____ Acute _____ Permanent _____ Temporary

Functional Capacity of the Individual

_____Unrestricted: No restriction need be placed on the individual relative to vigorousness or type of activity.

_____Minor Restriction: Ordinary physical activity need not be restricted, but unusually vigorous activity needs to be avoided.

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

_____Limited: Ordinary physical activity needs to be markedly restricted.

Medications

Is the Individual taking medication? YES NO If yes, for what purpose: _____

_____

Anatomical Analysis/Contraindicative Movements

Indicate joint and/or muscle groups in which physical activity should be limited or avoided.

Joint or Muscle Group & Direction of Movement Right, Left, or Both Limited or Avoided

1. _____
2. _____
3. _____

Other Relevant Information: Please use the backside of this page to state any other relevant medical information.

_____ Remedial (check if applicable): The individual's condition is such that defects or deviations can be improved or prevented from becoming worse through the use of carefully selected exercises. The following are types of exercises recommended for this individual's condition (please be specific).

_____

Physician's Name (please print) _____Date_____

Signed _____Phone_____

Address_____