Sports & Recreation Department

Health and Emergency Information

PRINT SAVE AS EMAIL RESET

Personal Information

Date: ___/___/_____

First Name _____ Last Name _____

Date of Birth ____/_____/_____ Age _____ Male ☐ Female ☐

E-mail Address _____

Primary Phone Number (_____) _____ Secondary Phone Number (____) _____

Address _____ City _____ State _____ Zip_____

If you live in a group home, please provide a contact name and phone number

_____

Parent (if under 18 years of age) or Legal Guardian Name _____

Parent/Guardian Phone Number _____ Email _____

Military Veteran: Yes☐ No☐ *If yes, branch of service* _____ *Dates of Service*_____

Referred By:

- ☐ Sports & Rec participant
- ☐ Physician or therapist
- ☐ Staff member
- ☐ SHARE
- ☐ School
- ☐ Other

Name of person referred by _____

Race/Ethnicity *(optional)*:

- ☐ Asia/Pacific Islander
- ☐ Black/African American
- ☐ Hispanic/Latino
- ☐ White/Caucasian
- ☐ Native American
- ☐ Other: _____

Emergency Contact Information

Emergency Contact _____ Relationship _____

Home Phone (_____) _____Work Phone (_____) _____

Cell Phone (_____) _____

Health Information

Height _____ Weight _____ T-shirt size _____

Mobility Type: Ambulatory ☐ Manual wheelchair ☐ Power wheelchair ☐ Other ☐

Allina Health
COURAGE KENNY REHABILITATION INSTITUTE

Please complete page 2.

Check any of the following that apply to your health (currently or in the past); this helps us anticipate sizing, equipment needs and safety concerns.

- ☐ Amputation - type: _____
- ☐ Arthritis
- ☐ Asthma
- ☐ Ataxia
- ☐ Autism
- ☐ Back/neck pain
- ☐ Brain injury
- ☐ Cancer - type:_____
- ☐ Cerebral palsy
- ☐ Chronic dizziness
- ☐ Circulatory disorder (e.g.. phlebitis, hypertension)
- ☐ COPD
- ☐ CVA
- ☐ Developmental delay
- ☐ Diabetes - insulin: Yes___ No___
- ☐ Epilepsy or seizure disorder

How many seizures in the past 12 months _____

Date of most recent seizure _____/_____/_____

- ☐ Fibromyalgia
- ☐ Fracture
- ☐ Head injury
- ☐ Hearing impairment
- ☐ Heart condition/heart-related problems *(if yes, explain)*_____ _____
- ☐ Language disorder (e.g., dysphagia, apraxia)
- ☐ Mental Disorder (e.g., ADD, ADHD, adjustment disorder) Diagnosis: _____
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ Musculoskeletal (e.g., degenerative disc disease)
- ☐ Neurological (e.g., migraines, ALS)
- ☐ Parkinson's Disease
- ☐ Post-polio Syndrome
- ☐ Respiratory disorder
- ☐ Shunt
- ☐ Spina Bifida
- ☐ Spinal cord injury - Level: _____
- ☐ Spinal Muscular Atrophy
- ☐ Stroke *(if yes, when and how affected):*_____
- ☐ Visual impairment
- ☐ Any other chronic medical condition *(please explain:)*_____

Medications *(prescription and over-the-counter):*

_____

Are you taking medications that may affect your exercise sessions? Yes_____ No _____

If yes, please explain: _____

_____

Allergies:_____

_____

I am currently receiving outpatient physical therapy: Yes_____ No _____

If yes, are you receiving physical therapy at a CKRI or Allina Health location? Yes_____ No _____

Important additional information for volunteer and/or other staff: _____

_____

_____

_____

_____

Return completed forms to:

Twin Cities-Metro: CKRISportsRecreation@allina.com Fax: 612-262-6718

Courage Kenny Rehabilitation Institute - Sports & Recreation, 3915 Golden Valley Road, Minneapolis, MN 55422

Northland-Duluth: CKRIDuluthSportandRec@allina.com

Courage Kenny Rehabilitation Institute – Northland, 200 Ordean Building, 424 W. Superior St.. Duluth, MN 55802

Allina Health
COURAGE KENNY REHABILITATION INSTITUTE

WAIVER AND LIABILITY RELEASE AGREEMENT:

Courage Kenny Rehabilitation Institution
800 East 28th Street
Minneapolis, MN 55407

I hereby agree, for myself and/or on behalf of my child and/or legal ward, heirs, administrators, personal representatives, assigns, and/or guests, if any, to the following:

That in consideration of **CKRI (Courage Kenny Rehabilitation Institution)** allowing my use of CKRI facilities and its locations and participation in its activities, under the terms set forth herein, I agree to hold harmless, release and discharge **CKRI**, its owners, agents, employees, personnel, sponsors, officers, directors, representatives, assigns, members, affiliated organizations, insurers, and others acting on its behalf (hereinafter collectively referred to as "ASSOCIATES"), of and from all claims, demands, causes of action and legal liability, whether the same be known or unknown, anticipated or unanticipated, due to **CKRI** and/or its ASSOCIATES' ordinary negligence; and I do further agree that, except in the event of **CKRI** and/or its ASSOCIATES' gross negligence and willful and wanton misconduct, I shall not bring any claims, demands, legal actions and causes of action, against **CKRI** and/or its ASSOCIATES as stated above in this clause, for any economic and/or non-economic losses due to bodily injury, death, property damage sustained by me and/or my minor children and/or legal wards, if any, in relation to the premises and/or operations of **CKRI**.

That if I engage in any physical activity or use of any **CKRI** facility on the premises, I agree to do so at my own risk and assume the risk of any and all injury and/or damage while engaging in any physical activity or use of any **CKRI** facility on the premises. My assumption of risk includes, but is not limited to, my use of any **CKRI** pediatric, exercise or rehabilitation equipment (mechanical or otherwise), the locker room, sidewalk, parking lot, stairs, pool, whirlpool, sauna, steam room, gymnasium, reception area or any equipment in any **CKRI** facility. I agree to assume this risk in my participation in any activity, class, program, service, instruction or **CKRI** sponsored event. I agree that I am VOLUNTARILY participating in **CKRI** activities and using **CKRI** facilities and premises and assume all risk of injury, harm, damage, or loss to me and my property that might result, including, without limitation, any loss or theft of any personal property.

In the event of illness or injury to my child, I authorize any official representative of **CKRI** to administer and/or secure medical treatment as deemed necessary by said representative.

This Agreement shall be governed by the laws of the State of Minnesota. If any of its provisions are held to be invalid or unenforceable by a court of competent jurisdiction, such holding shall not invalidate any of the other provisions of this Agreement, it being intended that the provisions of this Agreement are severable. I attest that I am fit and prepared to use **CKRI** facilities and participate in **CKRI** activities.

ACKNOWLEDGE THAT I HAVE CAREFULLY READ THIS WAIVER AND RELEASE AND FULLY UNDERSTAND THAT IT IS A RELEASE OF LIABILITY AND EXPRESS ASSUMPTION OF RISK. I AM AWARE AND AGREE THAT BY SIGNING THIS WAIVER AND RELEASE, I AM GIVING UP MY RIGHT TO BRING LEGAL ACTION OR ASSERT A CLAIM AGAINST **CKRI** FOR ITS NEGLIGENCE OR FOR ANY DEFECTIVE PRODUCT ON ITS PREMISES. I HAVE READ AND VOLUNTARILY SIGNED THE WAIVER AND RELEASE AND FURTHER AGREE THAT NO ORAL REPRESENTATIONS, STATEMENTS OR INDUCEMENT APART FROM THE FOREGOING WRITTEN AGREEMENT HAVE BEEN MADE.

Printed Name of Consumer: _____

Signature of Consumer: _____

or Parent/ Legal Guardian: _____ Date: _____

I understand that this Agreement also waives and releases **CKRI** liability for negligence causing any injury to my child and/or legal ward, heirs, administrators, personal representatives, assigns, and/or guests, if any. I attest that they are fit and prepared to utilize **CKRI** facilities and participate in **CKRI** activities.

Printed Name(s) of Minor(s) _____

Printed Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____ Date: _____

Allina Health
COURAGE KENNY REHABILITATION INSTITUTE

AUTHORIZATION FOR RELEASE OF INFORMATION

Courage Kenny Rehabilitation Institution
800 East 28th Street
Minneapolis, MN 55407

CONSUMER'S NAME: _____ **Date:** _____
(Please Print)

To provide services to you in the non-healthcare programs of Courage Kenny Rehabilitation Institution (CKRI) may need to use and disclose health-related information about you.

I AUTHORIZE CKRI TO DISCLOSE:

- Name, address, telephone number, e-mail address
  A. To be used in the team roster distributed to teammates, coaches and program volunteers.
  B. To assist in communication regarding team events, CKRI events and community events.
- Name, address, photos, electronic photos or videos
  A. Newspaper, television, radio, CKRI facilities and for use in marketing and fundraising.
  B. To increase publicity for the Sports and Recreation programs, individual sports or participants.

I understand that:

- This authorization must be filled out completely to be valid. A copy is as valid as the original.
- CKRI will not refuse to provide services to me based on my refusal to authorize the above mentioned disclosures.
- I may revoke this authorization at any time by notifying CKRI in writing. If I do, it won't affect any actions CKRI took in reliance on this authorization before I revoked it.
- Once information is released to a third party according to this authorization, CKRI cannot prevent its re-disclosure.

_____ _____
Signature of consumer Or consumer's representative **Date**

*If signed by consumer's representative, please PRINT YOUR name and describe relationship to consumer

Printed name: _____ Relationship to consumer: _____

You are entitled to a copy of this authorization form