Date: _____ Activity or class of interest: _____

PERSONAL INFORMATION

Legal Name: _____ Preferred Name: _____
Date of Birth: _____ Age: _____
Gender Identity: ☐ Male ☐ Female ☐ Prefer not to disclose Pronouns *(Optional)*: _____
Email Address: _____
Primary Phone Number: _____ Secondary Phone Number: _____
Address: _____
City: _____ State: _____ Zip: _____
Non-Verbal: ☐ Yes ☐ No Language Preference: _____
Military Veteran: ☐ Yes ☐ No If yes, what branch: _____ Dates of Service: _____

ADDITIONAL CONTACTS INFORMATION

Emergency Contact Name: _____ Relationship: _____
Phone Number: _____ Secondary Phone Number: _____
Parent/Legal Guardian Contact: *only for those under 18 years of age or have a legal guardian*
Parent/Legal Guardian Name: _____
Phone Number: _____ Email: _____
Group Home: Do you live in a group home? ☐ Yes ☐ No If yes, provide contact information:
Contact Name: _____ Contact Phone Number: _____

HEALTH INFORMATION

This information helps us anticipate safety concerns, potential accommodations, sizing, and equipment needs.
Height: _____ Weight: _____
Mobility Type: ☐ Walks independently ☐ Walks with assistance (cane/crutch/walker/trekking poles)
☐ Manual wheelchair ☐ Power wheelchair ☐ Other: _____
History of seizures: ☐ Yes ☐ No If yes, date of most recent seizure: _____
History of falls: ☐ Yes ☐ No If yes, date of most recent fall: _____
High blood pressure: ☐ Yes ☐ No If yes, explain: _____
Low blood pressure: ☐ Yes ☐ No If yes, explain: _____
Heart condition that changes with exercise: ☐ Yes ☐ No If yes, explain: _____
Respiratory problems that change with exercise: ☐ Yes ☐ No If yes, explain: _____
Allergies to Medications: ☐ Yes ☐ No If yes, explain: _____
Do you have a latex allergy? ☐ Yes ☐ No If yes, explain: _____
Are you taking medications that may affect your exercise sessions? ☐ Yes ☐ No
If yes, explain: _____

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR HEALTH CURRENTLY OR IN THE PAST:

☐ ADD/ADHD
☐ Amputation/Limb difference
If yes, type: _____
☐ Amyotrophic Lateral Sclerosis
☐ Asthma
☐ Ataxia
☐ Autism
☐ Back/neck pain
☐ Bowel/bladder incontinence or concerns
☐ Brain injury / TBI
☐ Cancer
If yes, type: _____
☐ Cerebral Palsy
☐ Chronic **dizziness/fainting/blackouts**
☐ Chronic pain and/or back pain
☐ **Circulatory disorder** (e.g. phlebitis, hypertension)
☐ **COPD**
☐ CVA/Stroke
Date: _____
How affected: _____
☐ Developmental delay/intellectual disability
If yes, diagnosis: _____
☐ **Diabetes**
If yes, do you take insulin: ☐ *Yes* ☐ *No*
☐ Down Syndrome
☐ **Epilepsy or seizure disorder**
How many seizures in the past 6 months: __
Date of most recent seizure: _____
☐ Fibromyalgia
☐ Fracture
☐ Hearing loss/hearing impairment
If yes, explain: _____
☐ **Heart condition / heart related problems**
If yes, explain: _____
☐ Huntington's Disease
☐ Language disorder (e.g. aphasia, apraxia)
☐ Learning disability
If yes, diagnosis: _____
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Musculoskeletal (e.g. degenerative disc disease, upper extremity/lower extremity)
☐ Neurocognitive Disorder
☐ Other: Congenital
If yes, explain: _____
☐ Other: Acquired
If yes, explain: _____
☐ Other: Neurological (e.g. migraines, ALS)
If yes, explain: _____
☐ Parkinson's Disease
☐ Post-Polio Syndrome
☐ **Respiratory Disorder**
☐ Shunt
☐ Spina Bifida
☐ Spinal Cord Injury
If yes, level: _____
☐ Spinal Muscular Atrophy
☐ Vision loss / vision impairment
If yes, explain: _____
☐ Any other chronic medical condition?
If yes, explain: _____

Please provide any additional important or helpful information for those working with you: _____

_____

_____

_____

Client Signature: _____ Date: _____
Client Signature: _____ Date: _____
Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____
Staff Signature: _____ Reviewed Date: _____
Staff Signature: _____ Reviewed Date: _____

Form is reviewed by patient/guardian and CKRI staff yearly.

WAIVER AND LIABILITY RELEASE AGREEMENT

Courage Kenny Rehabilitation Institute

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 Institute)** 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.

CORONAVIRUS / COVID-19 WARNING. Coronavirus, COVID-19 is a contagious virus that spreads easily through person- to-person contact. Federal and state authorities recommend social distancing and wearing a mask as ways to prevent the spread of the virus. COVID-19 can lead to severe illness, personal injury, permanent disability, and death. Participating in or accessing **CKRI's** programs or facilities could increase the risk of contracting COVID-19. **CKRI** in no way warrants that COVID-19 infection will not occur through participation at **CKRI** or the accessing of **CKRI's** facilities.

I agree, represent, and warrant that I will not visit or utilize **CKRI** facilities or services if I (i) experience symptoms of COVID- 19, including, without limitation, fever (over 100 degrees F), cough, shortness of breath, headache, diarrhea, loss of smell or taste, or (ii) have a suspected or diagnosed/confirmed case

of COVID-19. I agree to notify **CKRI** immediately if I believe that any of the foregoing access/use restrictions may apply. I acknowledge and assume both the known and potential dangers of utilizing **CKRI** facilities and services and acknowledge that use of them may, despite **CKRI's** reasonable efforts to mitigate such dangers, result in exposure to COVID-19, which could result in quarantine requirements, serious illness, disability, and/or death.

I 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: _____

Date: _____

THIS SECTION IS FOR INDIVIDUALS UNDER THE AGE OF 18 AND/OR HAVE A LEGAL GUARDIAN:

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)/Individual: _____

Printed Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____

Date: _____

Courage Kenny Rehabilitation Institute

Courage Kenny Rehabilitation Institute wants to provide the best care possible. To do so we depend on financial support from other agencies. These agencies require that we provide information about our patients and clients.

Providing this information is optional and **your information will be kept private**. Your care will not be affected by your choices below. We only share this information with our foundation to help acquire financial support.

IMPORTANT: This form is not a substitute for the cost-share application. Use the designated cost-share application to apply for cost-sharing.

1. Which category best describes your race?
   - ☐ Black, or African American
   - ☐ Asian
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ American Indian/Alaskan Native
   - ☐ White
   - ☐ Patient Declined

2. Which category best describes your ethnic group?
   - ☐ Hispanic or Latino
   - ☐ Not-Hispanic / Not Latino
   - ☐ Patient Declined

3. What language do you prefer when speaking to our staff? _____

4. **First,** check the number on the left that shows how many people are in your household. Make sure to include yourself. **Second**, on the same line check your household income.

Number of persons in household	(A) Income $0 up to	(B) Between	(C) Income above
☐ 1 →	☐ $0 to $12,490	☐ $12,491 - $24,980	☐ $24,980 +
☐ 2 →	☐ $0 to $16,910	☐ $16,911 - $33,820	☐ $33,821 +
☐ 3 →	☐ $0 to $21,330	☐ $21,331 - $42,660	☐ $42,661 +
☐ 4 →	☐ $0 to $25,750	☐ $25,751 - $51,500	☐ $51,501 +
☐ 5 →	☐ $0 to $30,170	☐ $30,171 - $60,340	☐ $60,341 +
☐ 6 →	☐ $0 to $34,590	☐ $34,591 - $69,180	☐ $69,181 +
☐ 7 →	☐ $0 to $39,010	☐ $39,011 - $78,020	☐ $78,021 +
☐ 8 →	☐ $0 to $43,430	☐ $47,851 - $95,700	☐ $95,701 +
☐ 9 →	☐ $0 to $47,850	☐ $43,431 - $86,860	☐ $86,861 +

THANK YOU!

Sports & Recreation participants only

AUTHORIZATION FOR RELEASE OF INFORMATION

Courage Kenny Rehabilitation Institution
3915 Golden Valley Rd
Minneapolis, MN 55422

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 redisclosure.

_____ _____
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

Allina Health
COURAGE KENNY REHABILITATION INSTITUTE