

Please check what you are registering for:

_____ PT initials

Aquatics Fitness Group exercise Sports & Recreation

Activity/Class: _____

Health and emergency information

Personal information

Date: _____

First name _____ Last name _____

Date of birth _____ Age _____ Male Female

Email 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 Staff member School _____

Physician or therapist SHARE Other: _____

Race/Ethnicity:

Asia/Pacific Islander Hispanic/Latino Native American

Black/African American White/Caucasian Other: _____

Emergency contact information

Emergency contact _____ Relationship _____

Home phone _____ Work phone _____ Cell phone _____

Primary physician _____ Clinic _____ Phone _____

Health information

Height _____ Weight _____ T-shirt size (Sport Rec only) _____

Mobility type:

Walks independently Walks with assistance

Power wheelchair Other _____



**COURAGE KENNY
REHABILITATION
INSTITUTE**

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.

ADD/ADHD
Amputation - type: _____
Amyotrophic Lateral Sclerosis
Arthritis
Asthma
Ataxia
Autism
Back/neck pain
Brain injury
Cancer - type: _____
Cerebral palsy
Chronic dizziness
Chronic pain and/or back pain
Circulatory disorder (e.g., phlebitis, hypertension)
COPD
CVA/Stroke (if yes, when and how affected):

Developmental delay/intellectual disability
Diabetes (if yes, do you take insulin): Yes No
Epilepsy or seizure disorder
How many seizures in the past 12 months _____
Date of most recent seizure _____
Fibromyalgia
Fracture
Hearing impairment

Heart condition/heart-related problems (if yes, explain):

Huntington's Disease
Language disorder (e.g., dysphagia, apraxia)
Learning disability
Mental Disorder (e.g., ADD, ADHD, adjustment disorder)
Diagnosis: _____
Multiple sclerosis
Muscular dystrophy
Musculoskeletal (e.g., degenerative disc disease)
Neurocognitive Disorder
Other: Congenital
Other: Acquired
Other: Neurological (e.g., migraines, ALS)
Parkinson's Disease
Post-polio Syndrome
Respiratory disorder
Shunt
Spina Bifida
Spinal cord injury - Level: _____
Spinal Muscular Atrophy
Visual impairment
Any other chronic medical condition (please explain):

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

If yes, please explain: _____

Allergies: _____

Seizures: Yes No If yes, date of last seizure: _____

High/Low blood pressure: Yes No If yes, please comment: _____

Heart condition that changes with exercise: Yes No If yes, please comment: _____

Respiratory problems: Yes No If yes, please comment: _____

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 including Stillwater: CKActive@allina.com Fax: 612-262-6718

Courage Kenny Rehabilitation Institute - CKActive, 3915 Golden Valley Road, Minneapolis, MN 55422

Northland (Duluth area): CKActive@allina.com Fax: 218-726-4759

Courage Kenny Rehabilitation Institute – Northland, 24 W. Superior St., 200 Ordean Building, Duluth, MN 55802

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.

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: _____

AllinaHealth 

COURAGE KENNY
REHABILITATION
INSTITUTE™

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

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 clients.

Providing this information is optional. Your care will not be affected by your choice. **Your individual information will be kept private.** We only share this information in summary form.

1. Which category best describes your race?

Black, African or African American

American Indian/Alaskan Native

Asian

Hawaiian or Pacific Islander

White

Declined to provide

2. Which category best describes your ethnic group?

Hispanic







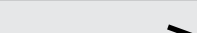

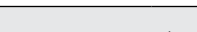
Unknown

Non-Hispanic

Refused

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 - 11,760	\$11,671 - 23,340	\$23,341 +
2 	\$0 - 15,730	\$15,731 - 31,460	\$31,461 +
3 	\$0 - 19,790	\$19,791 - 39,580	\$39,581 +
4 	\$0 - 23,850	\$23,851 - 47,700	\$47,701 +
5 	\$0 - 27,910	\$27,911 - 55,820	\$55,821 +
6 	\$0 - 31,970	\$31,971 - 63,940	\$63,941 +
7 	\$0 - 36,030	\$36,031 - 72,060	\$72,061 +
8 	\$0 - 40,090	\$40,091 - \$80,180	\$80,181 +
9 	\$0 - 44,150	\$44,151 - 88,300	\$88,301 +

Thank you!



**COURAGE KENNY
REHABILITATION
INSTITUTE**