Shirley Ryan AbilityLab Adaptive Sports and Fitness Program
Participant Medical Form

To be completed by participant

I am interested in joining: ☐ Fitness Center Only* ☐ Sports Program Only ☐ Both Sports and Fitness
*Enclose $35 Initiation Fee *Enclose $35 Initiation Fee

First Name: _____ Last Name: _____

Street Address: _____City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____ Home or Work Phone: (_____) _____

Date of Birth: _____/_____/_____ Email: _____ Military Veteran: YES NO

Diagnosis:

_____ Amputation Cause: _____ Level: _____
_____ Arthritis
_____ Cancer Type: _____
_____ COPD
_____ Cerebral Palsy
_____ Head Injury Cause: _____
_____ Multiple Sclerosis
_____ Parkinson's disease
_____ Stroke
_____ Spinal Cord Injury Cause: _____ Level _____ Complete Incomplete
_____ Visual Impairment
_____ Other: (Explain disability & cause) _____

Is your disability: Congenital (*present at birth*) Acquired or diagnosed on this date: ___/___/___

List surgeries and dates: _____

Medications (prescriptions and over-the-counter) _____

Allergies: _____

Please indicate if you have:

Seizures YES NO How many in the past 12 months: _____ Date of most recent seizure: ___/___/___

Diabetes	YES	NO	Use Insulin	YES	NO
Heart Disease	YES	NO	High Blood Pressure	YES	NO
Asthma	YES	NO	Heat Related Problems	YES	NO

Other: _____

I am currently receiving outpatient physical therapy: YES NO

If yes, are you receiving physical therapy at a Shirley Ryan AbilityLab location? YES NO

I give permission to the Shirley Ryan AbilityLab, Adaptive Sports and Fitness Program and or representatives from local competing organizing committees and /or local sport team representatives, to seek medical care on my behalf in the event of an emergency.

Signature of participant: _____ Date: ____/____/____

Signature of RIC Therapist (*If applicable*): _____ Date: ____/____/____

☐ **I have enclosed my $35 Initiation Fee. Please note the non-refundable Initiation Fee is required in order to process Shirley Ryan AbilityLab Fitness Center Memberships.**

Shirley Ryan Abilitylab

Office use only
Date received: ___/___/___
APP: _____
AMT: _____

THIS SIDE TO BE COMPLETED BY PHYSICIAN

Participant's Name: _____

Diagnosis: (List all) _____

List Impairments: (eg: Hemiparesis, etc…) _____

_____

Sex: M F Height: _____ Weight: _____ Pulse: _____ BP: _____

Physical Exam	**Normal**	**Abnormal**	**Explanation of abnormalities**
Head/Neck	_____	_____	_____
Eyes/Vision	_____	_____	_____
Ears/Hearing	_____	_____	_____
Heart/Lungs	_____	_____	_____
G.U.	_____	_____	_____
C.N.S.	_____	_____	_____
Skin	_____	_____	_____

If Lung Function and Bone Density results are available, please submit with completed form.

Orthopedic Exam

ROM Loss/Contractures: _____

Joint Laxity/Instability: _____

Other: _____

Dates of hospitalization in past two years with admitting diagnosis: _____

_____

Significant "ABNORMAL TEST" (EKG/X-Ray/Lab/DEXA): _____

APPROVAL FOR PARTICIPATION: YES NO

Comments/Restrictions: _____

_____

Physician Name: (Print) _____Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Physician's Signature: _____ Date: _____/_____/_____

Mail Completed Form To:
Shirley Ryan AbilityLab Adaptive Sports and Fitness Program
541 N. Fairbanks Court, Mezzanine, Chicago, IL 60611

OR

Fax Completed Form to: 312-238-5017

Call 312-238-5001 with questions