Shirley Ryan AbilityLab

Shirley Ryan AbilityLab Adaptive Sports & Fitness Program
Participant Medical Form

I am interested in Participating in: Functional Fitness ☐ Adaptive Sports Program Only ☐

First Name: _____ Last Name: _____

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

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

Date of Birth: _____/_____/_____ Email: _____

Military Veteran: YES NO

We never sell or share your email address. By providing your email, you opt in to receiving important program information, appointment reminders and other direct communication. We also send an occasional newsletter.

☐ **Check box if you wish to opt out of receiving newsletters and program updates. Note we will still send appointment remainders, direct communications, and other important program information.**

Diagnosis:

_____ Amputation: Level: _____ _____ Head Injury/TBI _____ Spinal Cord Injury: Level _____ Complete/Incomplete
_____ Cerebral Palsy _____ Multiple Sclerosis _____ Stroke
_____ COPD _____ Parkinson's disease _____ Visual Impairment
_____ Other: (Explain disability) _____

Is disability: Congenital (*present at birth*) YES NO **or** Acquired or diagnosed on this date: ___/___/___

Cause of disability _____

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	Heat Related Problems	YES	NO
Heart Disease	YES	NO	Asthma	YES	NO	High Blood Pressure	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 Therapist (*If applicable*): _____ Date: ____/____/____

PHYSICIAN APPROVAL FOR PARTICIPATION IN SPORTS OR FINTESS PROGRAMMING: YES NO

Comments/Restrictions: _____

_____

Physician Name: (Print) _____Phone: _____

Address: _____

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

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

OR

Email Completed Form To: sports@sralab.org
Fax Completed Form To: 312-238-5017
Call 312-238-5001 with questions