PRINT SAVE AS EMAIL RESET

CK Active

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 _____

Allina Health

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, 424 W. Superior St., Suite 201 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.

C**ORONAVIRUS / 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.

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

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

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
- ☐ Asian
- ☐ White
- ☐ American Indian/Alaskan Native
- ☐ Hawaiian or Pacific Islander
- ☐ Declined to provide

2. Which category best describes your ethnic group?

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown
- ☐ 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!

Allina Health

COURAGE KENNY REHABILITATION INSTITUTE

Move United Waiver & Release of Liability Agreement

Move United, and its affiliated Chapters ("Released Parties") are non-commercial, not for profit activity providers. The purpose of this Move United Waiver & Release of Liability Agreement is to exempt, waive, and relieve Released Parties from any and all liability for any harm, wrongful death, personal injury, property damage, claim or cause of action, including, but not limited to liability arising from the negligence of Released Parties. "Released Parties" include Move United, Allina Health System DBA Courage Kenny Rehabilitation Institute's Sports and Recreation, and their affiliates, successors, predecessors, parents, subsidiaries, owners, representatives, administrators, directors, officers, agents, coaches, employees, contractors, assigns, and volunteers; other participants, sponsoring agencies, sponsors, and advertisers; and, if applicable, the owners, operators, and lessors of premises on which the activities or events take place.

In consideration of the undersigned Participant being allowed to participate in any way in Move United and/or Allina Health System DBA Courage Kenny Rehabilitation Institute's Sports and Recreation related events and activities, the Undersigned ("Undersigned" means the Participant or the Participant's parent, legal guardian, or legal representative when the Participant is under the age of 18 or legally incapacitated) agrees and acknowledges as follows:

1. Risks of Activity. Participant will be taking part in activities that can be hazardous and involve the risk of physical injury and/or death. The activities are inherently dangerous and Undersigned fully realizes the dangers of participating in the activities. The dangers and risks of the activities include, but are not limited to the condition of the premises and equipment, and the acts, omissions, representations, carelessness, and negligence of the Released Parties. Recognizing the risks and dangers, the Undersigned voluntarily chooses for Participant to participate in the activities and expressly assumes all risks and dangers of the participation in the activity, whether or not described above, known or unknown, inherent, or otherwise.

2. Risks of Participation. The Undersigned recognizes and understands that while Released Parties have undertaken reasonable steps to lessen the risk of transmission of communicable diseases, including but not limited to, COVID-19, in connection with participation in the activities, the Released Parties are not responsible in any manner for any risks related to communicable diseases in connection with Participant's participation in the activities. Specifically, the Undersigned understands that COVID-19 is a highly contagious and dangerous disease, and that contact with the virus that causes COVID-19 may result in significant personal injury or death. The Undersigned is fully aware that participation in the activities carries with it certain inherent risks related to transmission of communicable diseases ("Inherent Risks") that cannot be eliminated regardless of the care taken to avoid such risks. Inherent Risks may include, but are not limited to, (1) the risk of coming into close contact with individuals or objects that may be carrying a communicable disease; (2) the risk of transmitting or contracting a communicable disease, directly or indirectly, to or from other individuals; and (3) injuries and complications ranging in severity from minor to catastrophic, including death, resulting directly or indirectly from communicable diseases or the treatment thereof. Further, the Undersigned understands that the risks of all communicable diseases are not fully understood, and that contact with, or transmission of, a communicable disease may result in risks to the Participant including but not limited to loss, personal injury, sickness, death, damage, and expense, the exact nature of which are not currently ascertainable, and all of which are to be considered Inherent Risks. The Undersigned hereby voluntarily accepts and assumes all risk of loss, personal injury, sickness, death, damage, and expense for the Participant arising from such Inherent Risks. Furthermore, the Undersigned represents and warrants that Participant does not knowingly carry any communicable diseases that may be transmitted during participation in the activities.

3. Release and Indemnification. Undersigned (a) unconditionally releases, forever discharges, and agrees not to sue the Released Parties for any claims or causes of action for any liability or loss of any nature, including personal injury, death, and property damage, arising out of or relating to Participant's participation in any Move United/Allina Health System DBA Courage Kenny Rehabilitation Institute's Sports and Recreation events or activities or the Participant's presence on or travel to the premises where such events or activities take place, including, but not limited to claims of negligence, breach of warranty, and/or breach of contract the Undersigned may or will have against the Released Parties; and (b) agrees to indemnify, defend, and hold harmless the Released Parties from and against any liability or damage of any kind and from any suits, claims, or demands, including legal fees and expenses whether or not in litigation, arising out of, or related to, Participant's participation in such events or activities or the Participant's presence on or travel to the premises where such events or activities take place.

4. Helmet Use. Undersigned agrees that Participant shall use a helmet when participating in the following activities: Alpine skiing, cycling, equestrian, ice hockey, outdoor rock climbing, snowboarding, white water kayaking, white water river rafting, and any other activity when directed by Released Parties. Undersigned understands that a helmet is in no way a guarantee of safety and that no helmet can protect the wearer against all foreseeable impacts to the head, and that the activities can expose the Participant to forces that exceed the limits of protection provided by a helmet. Undersigned agrees to assume full responsibility for complying with this paragraph and that Released Parties shall not be liable for any injury or damages resulting from Participant's failure to use a helmet.

Move United Waiver & Release of Liability Agreement

5. Medical Treatment. Undersigned understands that the Released Parties do not have medical personnel available at the location of the activities. Undersigned hereby grants the Released Parties permission to administer first aid or to authorize emergency medical treatment, if necessary. Undersigned understands and agrees that any such action by the Released Parties shall be subject to the terms of this agreement and release, including any liability arising from the negligence of the Released Parties when administering first aid or authorizing others to do so. Undersigned understands and agrees that the Released Parties do not assume responsibility for any injury or damage which might arise out of or in connection with such authorized emergency medical treatment.

6. Miscellaneous. Undersigned agrees (a) Participant will not engage in any activities prohibited by any applicable laws, statutes, regulations, and ordinances; (b) this Agreement shall be governed by the laws of the State of Minnesota and the exclusive jurisdiction and venue for any claim shall be located in the state courts located in Hennepin County, MN; (c) this Agreement shall be binding upon the subrogors, distributors, heirs, next of kin, executors, and personal representatives of the Undersigned; (d) this Agreement shall be construed as broadly as permitted by applicable law; and (e) that in the event that any clause or provision of this Agreement shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not otherwise affect the remaining provisions of this Agreement.

I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND ITS CONTENTS. I AM AWARE THAT I AM RELEASING LEGAL RIGHTS THAT OTHERWISE MAY EXIST. BY SIGNING BELOW, I HEREBY REPRESENT THAT I AM AT LEAST 18 YEARS OF AGE AND FULLY COMPETENT TO SIGN THIS AGREEMENT ON MY OWN BEHALF.

Participant's Signature	**Participant's Name (please print clearly)**	**Date**

FOR PARTICIPANTS UNDER THE AGE OF 18 OR LEGALLY INCAPACITATED

Undersigned parent, or legal guardian, or legal representative acknowledges that he/she is not only signing this Agreement on his/her behalf, but that he/she is also signing on behalf of the minor or legally incapacitated adult and that the minor or the legally incapacitated adult shall be bound by all the terms of this Agreement. Additionally, by signing this Agreement as the parent, or legal guardian, or legal representative of a minor or legally incapacitated adult, the parent, legal guardian, or legal representative understands that he/she is also waiving rights on behalf of the minor or legally incapacitated adult that the minor or legally incapacitated adult otherwise may have. The Undersigned parent, or legal guardian, or legal representative agrees that, but for the foregoing, the minor or legally incapacitated adult would not be permitted to participate in the activities. By signing below, I hereby represent that I am the parent, legal guardian, or legal representative of a minor, or legally incapacitated adult Participant and that I have the authority to sign on the Participant's behalf.

Minor's DOB	**Parent/Legal Guardian or Representative Signature**	**Parent/Legal Guardian or Representative Name**	**Relationship**	**Date**

Move United Media Release Agreement

Move United, and its affiliated Chapters ("Released Parties") are non-commercial, not for profit activity providers. "Released Parties" include Move United, Allina Health System DBA Courage Kenny Rehabilitation Institute's Sports and Recreation and their affiliates, successors, predecessors, parents, subsidiaries, owners, representatives, administrators, directors, officers, agents, coaches, employees, contractors, assigns, and volunteers; other participants, sponsoring agencies, sponsors, and advertisers; and, if applicable, the owners, operators, and lessors of premises on which the activities or events take place.

MEDIA RELEASE FORM

MEDIA/PHOTO WAIVER: Undersigned authorizes and gives full consent to Released Parties to copyright and/or publish for public view any and all photographs, digital recordings, videotapes, and/or film in which Participant appears. Undersigned agrees that Released Parties may transfer, use, or cause to be used, these digital recordings, photographs, videotapes, or films for any exhibitions, public displays, publications, commercials, art and advertising purposes, television programs, and internet without limitations or reservations.

Participant's Signature	**Participant's Name (please print clearly)**	**Date**

FOR PARTICIPANTS UNDER THE AGE OF 18 OR LEGALLY INCAPACITATED

Undersigned parent, or legal guardian, or legal representative acknowledges that he/she is not only signing this Agreement on his/her behalf, but that he/she is also signing on behalf of the minor or legally incapacitated adult and that the minor or the legally incapacitated adult shall be bound by all the terms of this Agreement. Additionally, by signing this Agreement as the parent, or legal guardian, or legal representative of a minor, or legally incapacitated adult, the parent, legal guardian, or legal representative understands that he/she is also waiving rights on behalf of the minor or legally incapacitated adult that the minor or legally incapacitated adult otherwise may have. By signing below, I hereby represent that I am the parent, legal guardian, or legal representative of a minor, or legally incapacitated adult Participant and that I have the authority to sign on the Participant's behalf.

Minor's DOB	**Parent/Legal Guardian or Representative Signature**	**Parent/Legal Guardian or Representative Name**	**Relationship**	**Date**

HSA INTERNATIONAL

ACTIVITY REGISTRATION FORM

[ ] OPEN WATER SCUBA COURSE [ ] ADVANCED SCUBA COURSE [ ] DIVE BUDDY COURSE
[ ] INSTRUCTOR COURSE [ ] INTRODUCTION TO SCUBA COURSE [ ] GUIDED DIVES
[ ] OTHER _____

PARTICIPANT'S NAME _____ BIRTH DATE _____ / _____ / _____
FIRST MIDDLE LAST MONTH DAY YEAR

ADDRESS _____

CITY/STATE/PROVINCE _____ POSTAL CODE _____

COUNTRY _____ TELEPHONE _____ EMAIL _____

HEIGHT _____ WEIGHT _____DISABILITY TYPE _____

HSA INSTRUCTOR NAME _____ HSA INSTRUCTOR # _____

INHERENT HAZARDS & RISKS OF DIVING ACTIVITIES
READ & SIGN BEFORE COMPLETING THE HSA LIABILITY RELEASE

To SCUBA DIVE safely you need to know a few basic rules & procedures that are very IMPORTANT because you are in and under the water, in the sun, around hard surfaces, and breathing compressed air. These safety rules and procedures will be covered in detail during your training course.

a. Breathe: This is the first rule, and it is completely up to you. It is very easy, you just breathe all the time, but it is the MOST IMPORTANT thing you will have to do. If you hold your breath you can rupture your lungs, which is VERY SERIOUS! This is called an Air Embolism and it can cause very serious injuries, even death.
b. Ears: Your ears may experience some pressure, or even hurt, when you descend underwater. This is normal, and you have probably already experienced this pressure in your ears if you have dove underwater, flown in an airplane, or driven in the mountains. You must 'equalize' this pressure, if you cannot it can cause damage to your ears and sinuses.
c. Sun: Wear sunscreen, you will burn easier around water, even if it is overcast!
d. Thermoregulation: Have water and shade available to avoid overheating.
e. Protective clothing: Keep your legs and feet covered. The pool and open water environments have hard and abrasive surfaces that can cause abrasions and tissue breakdown for people with reduced circulation.
f. Dive Duration: Because you are breathing compressed air underwater your body fluids and tissues absorb more nitrogen than at sea level. This build-up of nitrogen can cause decompression sickness (DCS). DCS can result in from mild to very serious injuries, even death. To avoid this we have 'no decompression limits' set for the time one can spend at various depths, making it easy to avoid.
g. Hard Surfaces: Place padding, such as an exercise mat or towel, on pool and boat deck surfaces, and on other hard surfaces, to protect the skin, if needed.
h. Transfer from your wheelchair: Be sure to tell those assisting your transfer what method you use, and then have them explain what they intend to do before they assist you. Have them lift your legs (not drag them) at the knee, so that your legs bend naturally. Be sure to tell them if you have poor balance and to provide support until you are stable.
i. Ascend: Swim slowly, 30 feet/minute, to the surface. Do NOT use a Buoyancy Control Devise (BCD) to ascend, swim to the surface, when your head breaks the surface, inflate the BCD, and attain positive buoyancy and comfort at the surface BEFORE removing your regulator. Swimming too fast to the surface can cause an Air Embolism, which is very serious.
j. Exit the water: Remove your weights, then Scuba unit. Be sure you have in-water and surface support. Exit the water, with assistance if necessary. Your in-water assistant will support your legs during the exit.
k. Recompression Chamber: A recompression chamber is needed to treat various diving related injuries, primarily Decompression Sickness and Air Embolism.

Participant Name _____ Signature _____ Date _____

Witness Name _____ Signature _____ Date _____

Name of Parent or Guardian _____ Signature _____ Date _____

HSA INTERNATIONAL

LIABILITY RELEASE AND EXPRESS ASSUMPTION OF RISK AGREEMENT

PARTICIPANT'S NAME _____ BIRTH DATE _____/_____/_____
FIRST MIDDLE LAST MONTH DAY YEAR

HSA INSTRUCTOR NAME _____ HSA INSTRUCTOR # _____

PLEASE READ CAREFULLY, ASK QUESTIONS IF NECESSARY, AND FILL IN ALL THE BLANKS BEFORE SIGNING.
CAUTION: READ & SIGN 'INHERENT HAZARDS & RISKS OF DIVING ACTIVITIES' BEFORE SIGNING THIS FORM.

I, _____, herby affirm and acknowledge that I am aware of the inherent hazards and risks of Snorkeling, Skin diving and Scuba Diving (hereinafter referred to as 'diving activities'). I fully understand that these risks can lead to severe injury and even death.

I understand that diving with compressed air involves risks of decompression sickness, embolism or other hyperbaric injuries that require treatment in a recompression chamber. I further understand that these diving activities may be conducted at sites that are remote by time and distance from a recompression chamber. Additionally, I understand that there are also risks involved with dive travel, including, but not limited to, dive boat accidents, and traveling to and from the dive sites. Nevertheless, I choose to proceed with such diving activities and I freely accept and expressly assume all risks, dangers and hazards that may arise from such diving activities which could result in injury, loss of life and property damage to me.

I understand and agree that neither the professional staff of _____, nor the facility _____, nor others _____, nor the Handicapped Scuba Association, nor its affiliate and subsidiary corporations, nor any of their respective employees, officers, agents or assigns, and volunteers, (hereinafter referred to as 'Released Parties') may be held liable or responsible in any way for the injury, death, or other damages to me or my family, heirs, or assigns that may occur as a result of my participation in these diving activities, or as a result of the negligence of any party, including the Released Parties, whether passive or active.

In consideration of being allowed to participate in these diving activities, as well as the use of any facilities and the use of equipment, I hereby personally assume all risks in connection with said diving activities, for any harm, injury or damage that may befall me while I am participating, including all risks connected therewith, whether foreseen or unforeseen.

I further save and hold harmless said diving activities and Released Parties from any claim or lawsuit by me, my family, estate, heirs, or assigns, arising out of my participation in these diving activities including claims arising during or after the diving activities.

I also understand that snorkeling, skin diving and scuba diving are physically strenuous activities and that I will be exerting myself during the diving activities, and that if I am injured as a result of, but not limited to, a heart attack, panic, or hyperventilation, that I expressly assume the risk of said injuries and that I will not hold the Released Parties responsible for the same.

I hereby declare that I am of legal age and competent to sign this agreement or, if not, that my parent or guardian shall sign on my behalf, and that my parent or guardian is in complete understanding and concurrence with this agreement.

I hereby state and agree that this agreement will be effective for all diving activities in which I participate until revoked in writing by the Released Parties.

I have read and understand this agreement, and agree to be bound by it.

Signature of Participant _____ Date _____/ _____/ _____

Witness Name _____ Signature _____

Name of Parent or Guardian _____ Signature _____

HSA INTERNATIONAL

MEDICAL HISTORY FORM

PARTICIPANT'S NAME _____ BIRTH DATE _____ / _____ / _____

FIRST MIDDLE LAST MONTH DAY YEAR

ADDRESS _____

CITY/STATE/PROVINCE _____ POSTAL CODE _____

COUNTRY _____ TELEPHONE _____ EMAIL _____

HEIGHT _____ WEIGHT _____DISABILITY TYPE _____

HSA INSTRUCTOR NAME _____ HSA INSTRUCTOR # _____

Medical History Questionnaire

The purpose of this questionnaire is to determine if you should be examined by a doctor prior to participating in a diver-training course. A positive response to a question does not necessarily disqualify you; it simply means you must seek approval from a doctor before engaging in diving activities.

____ Do you take prescription medication?
____ Are you, or could you be, Pregnant?*
____ Are you over 45 years of age?
____ Asthma, or wheezing with exercise*
____ Seizure disorder, epilepsy or convulsions*
____ Frequent colds, sinusitis or bronchitis
____ Severe hay fever or allergy
____ Pneumothorax, collapsed lung*
____ Lung disease
____ Chest surgery
____ Blackouts
____ Diabetes
____ Ear or sinus problems
____ Recurring Headaches or Migraines
____ Decompression sickness or diving accident
____ Behavioral health, mental or psychological (panic attacks, fear of open/ closed spaces)
____ Heart problems* _____
____ Heart or blood vessel surgery
____ High blood pressure medication
____ Pulmonary embolus*
____ Bleeding problems _____
____ Ulcers
____ Back problems _____
____ Back or spinal surgery
____ History of Surgery, description _____ _____
____ High blood pressure
____ Motion sickness
____ Head injury with loss of consciousness
____ Drug or alcohol treatment in past 5 years
____ History of Tracheotomy, why? _____
____ Physical disability (amputee, paraplegia, etc.)

PHYSICIAN

This person has applied for training, or is currently certified to engage in the sport of Scuba Diving. Based on a physical examination, your opinion of the applicants Medical Fitness for scuba diving is requested.

Physician's impression:

____ I find no Medical conditions that I consider incompatible with Scuba Diving.

____ I am UNABLE to recommend this person for Scuba Diving.

Remarks _____

_____, M.D. Date of Medical Exam ____/ ____ / _____
Physician's Signature

Physician Name _____ Telephone _____

Address _____, City _____, State ____, Zip Code _____

PARTICIPANT'S INFORMATION FORM, CONFIDENTIAL

Participant's Name _____ Telephone _____

Address _____ Email _____

City _____ State/Province _____ Postal Code _____

Country _____ Date of Birth _____ / _____ / _____

In case if emergency contact _____ Telephone _____

Are you a swimmer? _____ How long? _____ How well do you swim? Excellent [ ] Good [ ]

Do you have previous SCUBA diving and/or Snorkeling experience? _____

When? _____ Where? _____ Number of Dives? _____

What is your physical disability? _____

Do you have loss of sensory response (feeling)? _____ Where? _____

Do you use a catheter? _____ What type? Indwelling [ ] External [ ] Intermittent [ ] Other _____

Do you have a bowel program? _____ Have you developed decubiti? _____

Have you experienced Hyperreflexia (Autonomic Dysreflexia)? _____

Have you experienced Orthostatic Hypo-tension (low blood pressure)? _____

Has your respiratory system been affected? _____ Explain _____

Do you have a good cough reflex? _____ Explain _____

Are you able to perspire? _____ Do you have thermoregulation problems? _____

Do you have loss of muscle control in the mouth or lips? _____ Explain _____

Do you have speech impairment? _____ Explain _____

Do you have a hearing loss? _____ Explain _____

Explain any other medical conditions not covered _____

_____

Doctor's Name _____ Telephone _____

Address _____ City _____ State/Province _____

Country _____ Postal Code _____

Date _____ / _____ / _____