

**MEDICAL INFORMATION RELEASE FORM**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

The above individual would like to participate in the following:

- Bison Recreation Services Membership
- The following Bison Recreation Services program: \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN:**

- fully capable of participating
- capable of participating to a limited degree within the limitations noted below\*
- not capable of participating presently, but may be considered at a future date
- not capable of participating

\* Limitations or abnormalities that Bison Recreation Services should be aware of:  
 \_\_\_\_\_  
 \_\_\_\_\_

Signed: \_\_\_\_\_ - M.D.  
 Date: \_\_\_\_\_

**The following PAR-Q questions were answered positively:**

YES

- Q1. Heart condition
- Q2. Chest pain during activity
- Q3. Chest pain during rest
- Q4. Loss of balance, dizziness
- Q5. Bone or joint problem
- Q6. Blood Pressure or heart drugs
- Q7. Other reason: \_\_\_\_\_

**TO BE COMPLETED BY PATIENT:**

"I, \_\_\_\_\_, hereby agree to the release of the above information by my physician. Where my physician has indicated that I am capable of participating to a limited degree, I understand that it is my responsibility to discuss such limitations with my physician and follow my physician's recommendations. The University is not responsible for monitoring my activities."

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Inquiries may be directed to:**  
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