



## MEDICAL INFORMATION RELEASE FORM

Name:

Last name	First name	Middle initial

Address:

Address	City	Province	Postal code

Phone:

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### The above individual would like to participate in the following:

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

### TO BE COMPLETED BY THE 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 Recreation Services should be aware of:


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

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

### 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: \_\_\_\_\_

The following PARQ questions were answered POSITIVELY:  
(please circle)

- 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: \_\_\_\_\_