MULTIPLE SCLEROSIS EXERCISE PROGRAM

health.oregonstate.edu/ms-exercise

Oregon State University
College of Public Health and Human Sciences

Application

Participant's Name ________________________________

Please indicate which terms you are registering for this academic year.

TERM: FALL____ WINTER____ SPRING____ M/W class _____ Tues/Thurs class ____

Term Registration Fee $35.00 Paid_____ Scholarship needed_____

Please indicate the year you first started participating in the MS Exercise Program _________

Personal Contact Information

Phone ________________________________

Address ______________________________

____

E-mail _______________________________

Birthdate _____________________________

Video & Photograph Authorization for **Promotional** Purposes

Sign below for **exhibition or distribution** for any Multiple Sclerosis Exercise Program and/or OSU promotional purposes (print, web, video or audio) as the Multiple Sclerosis Exercise Program/OSU deems appropriate, without restriction or limitation (optional).

__________________________ __________________________
Signature of Participant Date

____

Revised 8-2014

Printed Name

Medical Information and Physician Release (to be filled out by your doctor)

Participant's Name ________________________________ Age _________ Gender M/F

Participant's Disease Course:
1. Benign Sensory ____________
2. Relapsing Remitting __________
3. Secondary Progressive___________
4. Primary Progressive___________

Age of Onset _________

Severity of Condition: Mild _________ Moderate ________ Severe __________

Functional Capacity of Participant:

________ Unrestricted	No restriction need to be placed on the participant relative to intensity or type of activity
________ Restricted	Participant's condition is such that the intensity and type of the activity need to be limited
________Mild Restriction	Ordinary physical activity need not be restricted but unusually vigorous efforts need to be avoided.
________Moderate Restriction	Ordinary physical activity need to be moderately restricted and sustained strenuous efforts need to be avoided.
________ Maximal Restriction	Ordinary physical activity needs to be markedly restricted.

Is the participant taking any medications? (yes or no)

If yes, please list. ____

____

Dr's Signature: __________________________ Date: _____________

Dr's Name (please print) & phone number: ____________________________

This page and the next are to be filled out by participant

MS EXERCISE PROGRAM
Emergency Treatment Release Form

Participant's Name____

Home Address ____

____

____

Home Phone ________________________ Cell Phone __________________

Email ______________________________

Doctor's Name _________________________ Doctor's Phone _____________________

Hospital at which you're usually treated ____

Emergency Contact _____________________________________

Contact's Day Phone Number __________________ Contact's Cell Phone _____________

In the event that I should, for any reason, require minor medical care or emergency medical treatment during the course of the MS Exercise Program, I consent to receive such assistance by appropriate staff or medical personnel. I will not hold the university or personnel involved in the program legally responsible for injury or accidents which may occur.

____________________________________ ________________________

Participant's Signature Date

Video & Photograph Authorization for Educational Purposes

I, the undersigned, hereby authorize the use of video, audio, photographs taken by the program coordinator of the OSU Multiple Sclerosis Exercise Program, to be used to help train student volunteers who work in our program. It will be used primarily to teach new volunteers about characteristic signs and symptoms of MS including gait changes, transfers and other functional abilities (optional).

_________________________ _______________________

Signature of Participant Date

____

Printed Name

MS EXERCISE PROGRAM

Participant Consent Form

I, on my own behalf, make the following representations and releases:

1. I must a have a medical doctor's referral in order to participate in the program.
2. I understand that an assessment will be needed upon entering the program to determine my present level of function and muscle strength. Such information will be used to plan and implement an individualized exercise program. Periodic reassessment may also be scheduled to evaluate progress.
3. I realize that any devices, equipment, etc. needed to participate in the program (other than those typically provided in the program) must be supplied by the individual.
4. I will not hold the MS Exercise Program liable for any accident or injury incurred while participating in said program. I understand that the cost of the coverage for medical expenses for accident or injury is the participant's responsibility.
5. I realize that medical information and related data may be shared with supervisors and interns within the program for educational purposes.

The directors, agents, employees or students of Oregon State University are hereby released, acquitted, and discharged from any claims for damage or suit by reason of injury, illness or damage to person or property during the course of the MS Exercise Program, including transportation to and from the program.

I have read and fully understand the provisions of the above consent from and agree to its terms and conditions.

Participant's Signature ____

Date __________________