

Oregon State University
College of Public Health and Human Sciences

Multiple Sclerosis Exercise Program

health.oregonstate.edu/ms-exercise

MS Exercise Application

Personal Contact Information:

First Name: _____ Last Name: _____

Cell Phone: _____ Home Phone: _____

Street Address: _____ City: _____

State: _____ ZIP Code: _____

E-mail: _____

Date of Birth – Day: _____ Month: _____ Year: _____

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

For Monday/Wednesday participants:

Do you need an OSU parking permit? YES NO

This is required if you do **not** ride a bus **and** your car will be staying on campus for a few minutes because a person/care giver drops you off or the car is on campus for the full hour. (The permit is required even if you have an ADA permit)

MS EXERCISE PROGRAM
Emergency Treatment Release Form

Emergency Contact:

First Name: _____ *Last Name:* _____

Home Phone: _____ *Cell Phone:* _____

Email: _____

Doctor or primary care physician contact:

Doctor's Name: _____ *Doctor's Phone:* _____

Hospital at which you're usually treated: _____

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

This next section is to be filled out by your doctor or primary care physician.

Medical Information and Physician Release

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 Name: _____ Phone Number: _____

Doctors Signature

Date

MS EXERCISE PROGRAM
Participant Consent Form

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

1. I must 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 form and agree to its terms and conditions.

Participant's Signature

Date

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).

Participant's Signature

Date

Printed Name