



Parkinson Partners of NW PA, Inc.
PO Box 10547
Erie, PA 16514
814-899-3030
Fax: 814-616-7766
Email: info@ParkinsonPartners.org



Parkinson Partners of NW PA Purposeful Movement and Wellness Program Application, Waiver and Medical Release Form

Participant Application:

Name: _____ DOB: _____

Address: _____ City: _____ Zip code: _____

Home Telephone: _____ Work/Cell Phone: _____

Email: _____

Emergency Contact Name: _____ Phone #: _____

Where did you hear about this program? _____

What activities are challenging to you? (Please check all that apply.) Please list any other issues you think we should know (hearing or vision issues, injuries, health concerns, etc.)

Standing___ Walking___ Speaking___ Dressing___ Other_____

Please explain. _____

“It is important that you understand the inherent risk of exposure to COVID-19 exists in any public place where people are present. According to the Centers for Disease Control and Prevention, senior citizens and those with underlying medical conditions are especially vulnerable. All attendees of Parkinson Partners of NW PA’s in-person events and classes must agree to adhere to our guidelines and the guidelines of our community partners and voluntarily assume all risks related to exposure to COVID-19. We also encourage you to stay home if you are feeling unwell or if you have been exposed to Covid-19, the flu or any other virus.”

\$80 Class Fee enclosed: ___yes ___no *Make checks payable to: Parkinson Partners of NW PA*

Participant Waiver Enclosed: ___ yes___ no

Neurologist Release Enclosed: ___yes ___ no

Neurologist’s name/phone number: _____

PARTICIPANT WAIVER & RELEASE FORM

You have agreed to participate in the Purposeful Movement and Wellness Program. This program will provide exercise/education tailored to people with Parkinson’s disease.

Because physical exercise can be strenuous and subject to risk, Parkinson Partners of Northwestern Pennsylvania and Gannon University requires a medical release from your doctor before using exercise equipment or participating in any exercise activity or class. You agree that if you engage in any physical exercise or activity, or use any facility amenity on the premises during the session, you do so **entirely at your own risk**.

This includes, without limitation, your use of the exercise gym, parking area, and sidewalk area, or any equipment in the facility and your participation in any activity, class, program or instruction. You agree that you are voluntarily participating in these activities along with the use of the facilities and surrounding premises in which they occur and **assume all risks of injury**, illness, damage or loss or theft of any personal property.

You expressly agree to release and discharge Parkinson Partners of Northwestern Pennsylvania/Gannon University/Salvation Army and all affiliates, employees, therapists, students, and representatives from any and all claims or causes of action. This waiver and release of liability includes, without limitation, all injuries to you which may occur as a result of (a) your use of any exercise equipment, products and facility amenities, (b) the sudden and unforeseen malfunctioning of any equipment (c) our instruction or supervision, and (d) your slipping and/or falling while in the hosting facility, or on the facility premises including adjacent sidewalks and parking areas and surrounding premises **regardless of negligence**.

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Your signature acknowledges you have carefully read this waiver and release and fully understand it is a release of liability. You agree to voluntarily give up any right you may otherwise have to bring a legal action against the Parkinson Partners of Northwestern Pennsylvania, Gannon University, Salvation Army and all affiliates, employees, therapists, students, and representatives for negligence, or any other personal injury or property damage or loss action.

Print Name

Signature

Date

***Please send your completed application, medical release form signed by your neurologist and your payment of \$80 to:**

**Parkinson Partners Wellness Program
PO Box 10547
Erie, PA 16514**



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PD Purposeful Movement and Wellness Program Neurologist Medical Release Form

Patient's Name: _____ DOB: _____
 Address: _____ City: _____ Zip code: _____
 Home Telephone: _____ Work/Cell Phone: _____

Dear Doctor:

Your patient _____ wishes to attend an 8-week in-person wellness program specialized for people with Parkinson's disease. The program will include sub-maximal physical exercises and education designed to improve independence with gait, functional mobility, and daily living skills. Program activities are provided by faculty and students from Occupational and Physical Therapy programs at Gannon University.

Neurologist's Recommendations

Note: Appropriate participants must be able to follow one step commands and ambulate with or without an assistive device (with no additional assistance from another person).

Participant has been diagnosed with: Idiopathic PD Atypical PD

Participant is alert, oriented, and can follow directions. Yes___ No___

Participant is ambulatory with or without an assistive device. Yes___ No___
 (no additional assistance from another person)

Participant can engage in all program activities. Yes___ No___

Participant is approved for the PD wellness program. Yes___ No___

Precautions _____

Neurologist's signature		Date
Neurologist's name (print)	Phone	Fax
Address	City	State & Zip

Email to info@parkinsonpartners.org or Fax (HIPAA Compliant): (814) 616-7766

Questions--Please Call: Lynne Gotham, Executive Director of Parkinson Partners of NW PA
 Phone: 814-899-3030