Community:_____ College staff/Faculty: _____ Student: _____ HealthFirst_____
Projected Graduation Date: _____

Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ Zip Code: _____

Primary Phone: _____ E-mail Address: _____

Emergency Contact: _____ Emergency Phone #:_____

PAR-Q

1.)HAS YOUR DOCTOR EVER SAID THAT YOU HAVE A HEART CONDITION AND THAT YOU SHOULD ONLY PERFORM PHYSICAL ACTIVITY RECOMMENDED BY A DOCTOR? YES/NO

2.)DO YOU FEEL PAIN IN YOUR CHEST WHEN YOU PERFORM PHYSICAL ACTIVITY? ACTIVITY? YES/NO

3.)IN THE PAST MONTH, HAVE YOU HAD CHEST PAIN WHEN YOU WERE NOT PERFOMRING NOT PERFORMING PHYSICAL ACTIVITY? YES/NO

4.)DO YOU LOSE YOUR BALANCE BECAUSE OF DIZZINESS OR DO YOU EVER LOSE CONSCIOUSNESS? YES/NO

5.)DO YOU HAVE A BONE OR JOINT PROBLEM THAT COULD BE MADE WORSE BY A CHANGE IN YOUR PHYSICAL ACTIVITY? YES/NO

6.)IS YOUR DOCTOR CURRENTLY PRESCRIBING ANY MEDICATIONS FOR YOUR BLOOD PRESSURE OR FOR A HEART CONDITION? YES/NO

7.)ARE YOU CURRENTLY TAKING ANY MEDICATIONS OR OVER THE COUNTER DRUGS? YES/NO
IF YES, PLEASE LIST BELOW AS THEY MAY HAVE COUNTER-INTUITUVE EFFECTS WHEN PERFORMING EXERCISE.
_____

8.)DO YOU KNOW OF **ANY** OTHER REASON WHY YOU SHOULD NOT ENGAGE IN PHYSICAL ACTIVITY? YES/NO
ENGAGE IN PHYSICAL ACTIVITY?

*IF YOU ANSWERED **YES** TO ANY OF THE ABOVE QUESTIONS, CONSULT YOUR **PRIMARY CARE PROVIDER (PCP)** BEFORE BEGINNING A NEW ACTIVITY REGIMENT. ADDRESS THE QUESTIONS THAT YOU ANSWERED YES TO WITH YOUR **PCP** AND ASK FOR GUIDANCE ON WHAT TYPE OF ACTIVITY YOU WILL BE IDEAL FOR YOUR CURRENT CONDITION.* SOURCE: NATIONAL ACADEMY OF SPORTS MEDICINE

++++++++++++++++++++++++++++++++++STAFF USE ONLY ++

IS A MEDICAL RELEASE NEEDED? YES NO STAFF INITIALS
(IF YES – HAVE THEM COMPLETE ONE- SEND TO DR AND LIMIT ACTIVITY UNTIL CLEARED)

CONSENT, USE AND DISCLOSURE STATEMENT

I understand that I have a right to restrict CMCC and its affiliates use and disclosure of my PHI and that CMH and its affiliates is not obligated to agree to the requested restrictions, but that an agreement to a restriction binds CMH and its affiliates. I may revoke this consent at any time providing CMCC and its affiliates with a written, signed, and dated request except to the extent that CMCC and all affiliates have acted in reliance upon my consent. However, I understand that any restriction on the use and disclosure of PHI or revocation of this consent may result in improper diagnosis or treatment, denial of coverage of a claim for insurance benefits, or other adverse consequences.

I acknowledge this consent will remain in effect for all subsequent uses and disclosures for the limited purposes outlined above for 30 months from the date of this consent, unless I revoke it earlier, as described above.

I understand that CMCC and its affiliates regard the safeguarding of PHI as an important duty. I understand, furthermore, that the elements of this consent are required by state and federal law for my protection and to ensure my informed consent to the use and disclosure of PHI necessary to support my relationship with CMCC and all its affiliates.

_____ **(Initial) Notice of Privacy: I have received a copy of CMCC and all affiliates' Notice of Privacy Practices, which provides a more complete description of the uses and disclosures addressed above. I acknowledge that CMCC and its affiliates reserve the right to amend the Notice of Privacy Practices periodically. I understand that I may obtain a current copy of the Notice by contacting CMCC at any time.**

I understand, if I have a question about this consent or about CMCC and all affiliates privacy practices, or if I want to have a copy of this consent, I may ask the office staff or my provider.

_____ (Initial) **Valuables Responsibility:** The CMCC policy on valuables has been explained to me; CMCC and affiliates are not responsible for my lost or damaged personal items.

_____ (Initial) **I understand the English language in its written and oral form; I do not require the services of an interpreter or reader. I have read this consent completely. I have crossed out any words or phrases I do not accept. I understand I can have a copy of this form upon request.**

X _____/_____; ____/____/_____
Printed Name and Signature of Patient (or Authorized Legal Representative) **Date**

X _____/_____; ____/____/_____
Witness to Patient Signature (or Authorized Legal Representative) **Date**