CITY OF CARSON

Recreation and Human Services
Joseph B. O'Neal, Jr. Stroke Center Application

TO BE ELIGIBLE YOU MUST HAVE HAD A STROKE AT LEAST 6 MONTHS AGO.

RELEASE AND ASSUMPTION OF RISK FORM
SWIMMING AND VARIOUS FORMS OF EXERCISE CAN BE DANGEROUS. THIS IS A WAIVER AND RELEASE. READ IT CAREFULLY BEFORE YOU SIGN IT.

I, _____ , wish to participate in the Joseph B. O'Neal, Jr. Stroke Center sponsored by the City of Carson ("the City"). I understand that the exercise program will consist of various forms of exercise including, but not limited to stretching, chair exercise, light weights, low impact aerobics, swimming and exercises in the swimming pool. I have discussed the exercise program with my physician who has advised me of my medical limitations in any exercise program and has authorized my participation. I have provided the City with an authorization form signed by my physician.

I understand that any swimming pool and any other activities taking place in and around the pool may have inherent dangers and risks. Recognizing these risks as inherent dangers, this release hereby acknowledges my assumption of these risks, and furthermore, this release acknowledges that I will not hold the City liable for injury or damages connected with those inherent dangers and my participation in this exercise program. In the event of a medical emergency, I authorize the medical personnel attending me to make decisions regarding my immediate medical treatment as may be necessary.

Accordingly, I, for myself, my heirs, executors, administrators, and assigns, hereby release and discharge the City of Carson, the Carson Redevelopment Agency, and their respected elected officials, officers, attorneys, agents, employees, volunteers, successors, and assigns (collectively the "Organizers") from and against any and all claims, demands, and/or causes of action of losses, injuries, damages, cost, and/ or liabilities, including personal injury and property damages arising out of or in any way attributable to or in connection with my participation in the exercise program. Moreover, I expressly release the Organizers from and against any and all claims or liability arising from their negligence in organizing, planning, and/or implementing this program.

I HAVE READ THIS RELEASE AND ASSUMPTION OF RISK CAREFULLY. I UNDERSTAND THE RISKS INVOLVED IN PARTICIPATING IN THE EXERCISE PROGRAM. I AM FULLY PREPARED TO ACCEPT THESE RISKS.

I AM AWARE THAT THE JOSEPH B. O'NEAL, JR. STROKE CENTER RESERVES THE RIGHT TO REFUSE SERVICES TO ANYONE.

I UNDERSTAND THAT BY SIGNING THIS RELEASE, I GIVE UP MY RIGHT TO SUE THE ORGANIZERS OF THE EXERCISE PROGRAM IF I AM HURT OR INJURED, EVEN IF THEY ARE NEGLIGENT.

Participant's signature: _____

Participant's Name (please print): _____

Address/City/Zip Code: _____

Telephone: _____ Date: _____

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Sessions are supervised by a Certified Physical Therapist, Licensed Occupational Therapist, and Speech Pathologist.

Sessions consist of stretching exercises, muscle strengthening by the use of TheraBands and/or small weights, chair exercises, swimming, warm water exercise, and other exercises deemed appropriate for stroke survivors by the instructor.

PHYSICIAN AUTHORIZATION FORM

I have reviewed the program description that _____ has provided me. I am familiar with my patient's medical condition and hereby authorize his/her participation in the City of Carson Stroke Survivor Support Services Exercise/Therapy Program.

_____ _____
Signature of Physician Date

_____
Physician's Name (print please)

_____
Address/City/ Zip

_____
Phone Number

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CLIENT RELEASE FORM

I, _____ , wish to participate in the Stroke Survivor Support Services Program sponsored by the City of Carson ("the City").

I understand that the Support Group Program will consist of interaction with other stroke survivors or caregivers and may involve intense emotional and sensitive subjects and may invoke negative reactions from participants. I have provided the City with an authorization form signed by my physician and understand that I am participating willingly and knowingly in the City's Support Group Program.

I, for myself, my heirs, executors, administers, and assigns, hereby release and discharge the City and their respective agents, officers, servants, contractors, and employees ("the organizers") from any and all claims for losses, injuries, damages or liabilities, including personal injury and injury to personal property, arising out of or attributable to my participation in the Support Group Program. I expressly release and hold harmless the organizers from any and all claims or liabilities arising from their joint or several negligence in organizing planning, and implementing the Support Group Program.

I HAVE READ THIS RELEASE CAREFULLY.

I UNDERSTAND THE RISKS INVOLVED IN PARTICIPATING IN THE SUPPORT GROUP PROGRAM.

I AM FULLY PREPARED TO ACCEPT THESE RISKS.

Participant's Signature: _____

Participant's Name (please print): _____

Date: _____

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Sessions are supervised by a licensed facilitator.

I understand the support group will consist of interaction with other stroke survivors or caregivers and may involve intense emotional and sensitive subjects and may invoke negative reactions from participants. I am providing the City with an authorization form signed by my physician and understand that I am participating willingly and knowingly in the City's Support Group Program.

PHYSICIAN AUTHORIZATION FORM

I have reviewed the program description that _____ has provided me. I am familiar with my patient's medical condition and hereby authorize his/her participation in the City of Carson Stroke Survivor Support Group Program.

_____ _____
Signature of Physician **Date**

_____
Physician's Name (print please)

_____
Address/City/Zip Code

_____
Phone Number

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PHYSICIAN RELEASE FORM

Participant's Name: _____

Referring Physician: _____

Physician's Address: _____

Phone Number: _____

Primary Medical Diagnosis and DATE OF STROKE:

_____
_____
_____

Secondary Diagnosis or Other Medical Conditions: (Please include joint replacement, pacemakers, etc.)

_____
_____
_____

Current Medications Prescribed:

_____
_____
_____

Does the participant have seizures? { } YES { } NO

If yes, please describe:

_____
_____

Does the participant have allergies? { } YES { } NO

If yes, please describe:

_____
_____

_____ _____

Physician's Signature: **Date:**

THIS PAGE IS TO BE COMPLETED BY THE PARTICIPANT'S PHYSICIAN ONLY.
SIGNING THIS FORM CERTIFIES THAT PARTICIPANT HAS HAD A STROKE

Joseph B. O'Neal. Jr. Stroke Center
Water Exercises Class

The water exercise class uses the natural resistance of the water to develop muscle tone, strength, flexibility and endurance while minimizing trauma to the weight bearing joints. The Water Exercises Class takes place every Wednesday at the Ability First Pool, located in Long Beach. Classes are lead by the ability First aquatics staff and are approximately 50 minutes long. The water is heated to 88 degrees. The AbilityFirst facility including pool, dressing rooms, and showers are all wheelchair accessible.

PHYSICIAN AUTHORIZATION FORM

I HAVE REVIEWED THE PROGRAM DESCRIPTION THAT _____ HAS PROVIDED ME. I AM FAMILIAR WITH MY PATIENT'S MEDICAL CONDITION.

( ) I HEREBY AUTHORIZE HIS/HER PARTICIPATION IN THE WATER EXERCISE CLASS.

( ) I DO NOT AUTHORIZE HIS/HER PARTICIPATION IN THE WATER EXERCISE PROGRAM AT THIS TIME

_____ _____
SIGNATURE OF PHYSICIAN **DATE**

_____
PHYSICIAN'S NAME (PRINT NAME)

_____
ADDRESS/CITY/ ZIP CODE

_____
PHONE NUMBER