

**CITY OF PHILADELPHIA DEPARTMENT OF RECREATION
CAROUSEL HOUSE**
Belmont Ave. & N. Concourse Dr.
Philadelphia, PA 19131
GENERAL #:685-0160 AQUATICS #:685-0163 FAX #:581-2945
MEDICAL QUESTIONNAIRE
PLEASE PRINT LEGIBLY

NAME: _____ D.O.B.: ____/____/____
ADDRESS: _____
CITY _____ STATE: _____ ZIP: _____ SEX: _____
TELEPHONE #: _____ WORK #: _____

EMERGENCY CONTACT: PLEASE PRINT

NAME: _____ RELATIONSHIP: _____
TELEPHONE #: _____ WORK #: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

PHYSICIAN: PLEASE PRINT

NAME: _____ TELEPHONE #: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

FOLLOWING SECTION MUST BE COMPLETED BY PHYSICIAN: PLEASE PRINT

NATURE OF DISABILITY: _____ DATE OF ONSET: _____

MEDICATIONS & ALLERGIES: _____

MEDICAL CONTRAINDICATIONS: _____

PAST MED, HX. : _____

PRECAUTIONS/LIMITATIONS TO BE OBSERVED: _____

DOCTOR'S COMMENTS/ RECOMMENDATIONS FOR INDIVIDUALIZED EXERCISED PROGRAM: _____

Feel free to call Carousel House Staff if there are any questions about the programs or its goals.

Please state that the individual which appears on this form is in good Health and that he/she may participate in a: **Weight Training Program** [], **Aquatic Program** [], or **Athletic Program** [].

Signature Date

Physicians I.D. #

DATE RECEIVED AT CAROUSEL HOUSE: _____

THIS FORM MUST BE RENEWED ON: _____