

**CITY OF PHILADELPHIA – PARKS & RECREATION
CAROUSEL HOUSE**

C/O Gustine Recreation Center
4868 Ridge Avenue
Philadelphia, PA 19129

GENERAL #: 215-685-0160 FAX #: 215-685-0189

EMAIL: carouselpa@gmail.com

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: **Aquatic Program** [], or **Athletic Program** [].

Signature

Date

Physicians I.D. #

DATE RECEIVED AT CAROUSEL HOUSE: _____

THIS FORM MUST BE RENEWED ON: _____