**CITY OF PHILADELPHIA DEPARTMENT OF RECREATION**
**CAROUSEL HOUSE**
4300 AVENUE OF THE REPUBLIC
Philadelphia, PA 19131-3706
GENERAL #:215-685-0160 AQUATICS #:215-685-0163 FAX #:215-581-2945

**MEDICAL QUESTIONNAIRE**
**PLEASE PRINT LEGIBLY**

NAME:______________________________________ D.O.B.: _____/_____/_____
ADDRESS:_______________________________________________________________
CITY _ ____________________ STATE: _________ ZIP: __________ SEX: __________
TELEPHONE #: ______________________ WORK #: ________________

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**EMERGENCY CONTACT: PLEASE PRINT**
NAME: __________________________________ RELATIONSHIP:________________
TELEPHONE #: _______________________ WORK #: _____________________
ADDRESS: ______________________________________________________________
CITY: ___________________ STATE: _____________ ZIP: ____________

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**PHYSICIAN: PLEASE PRINT**
NAME: _______________________________ TELEPHONE #: ________________
ADDRESS: ______________________________________________________________
CITY: ___________________ STATE: _____________ ZIP: _____________

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**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:__________________________**