

Physical Activity Release, Waiver and Questionnaire

Name \_\_\_\_\_ Phone (hm) \_\_\_\_\_ (wk) \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Regular physical activity is safe for most people, however, you should check with your doctor before starting to exercise. To keep the leaders informed, please read the following questions carefully and answer each one honestly. All information will be kept confidential.

**YES NO (Please check YES or NO)**

\_\_\_\_\_ Are you in good health?

\_\_\_\_\_ Do you have a heart condition?

\_\_\_\_\_ Have you ever experienced a stroke?

\_\_\_\_\_ Do you have epilepsy?

\_\_\_\_\_ Do you have diabetes?

\_\_\_\_\_ Do you have emphysema?

\_\_\_\_\_ Do you feel pain in your chest when you engage in physical activity?

\_\_\_\_\_ Do you have chronic bronchitis?

\_\_\_\_\_ In the past month, have you had chest pain when you were not doing physical activity?

\_\_\_\_\_ Do you or have you ever lost consciousness or lost control of your balance due to chronic dizziness?

\_\_\_\_\_ Are you currently being treated for a bone or joint problem that restricts you from engaging in physical activity?

\_\_\_\_\_ Do you experience pain in a joint from exertion (tendon, ligament, cartilage, bursar sacs, etc.)? Describe \_\_\_\_\_

\_\_\_\_\_ Are you currently or have you experienced back pain in the past? Describe \_\_\_\_\_

\_\_\_\_\_ Has a physician ever told you or are you aware that you have high blood pressure?

\_\_\_\_\_ Has anyone in your immediate family (parents/brothers/sister) had a heart attack, stroke or cardiovascular disease before 55?

\_\_\_\_\_ Has a physician ever told you or are you aware that you have a high cholesterol level?

\_\_\_\_\_ Do you currently smoke or have you smoked in the past two (2) years?

\_\_\_\_\_ Are you over 44 years of age?

\_\_\_\_\_ Are you currently exercising LESS than 1 hour per week? If you answered NO, please list your activities. \_\_\_\_\_

\_\_\_\_\_ Are you currently taking any medication? If so please list the medication and its purpose \_\_\_\_\_

\_\_\_\_\_ Have you had any surgeries and/or hospitalizations? If yes, please explain. \_\_\_\_\_

\_\_\_\_\_ List any health condition that could adversely affect you during physical exercise. \_\_\_\_\_

\_\_\_\_\_ Do you know of any other reason why you should not do physical activity? Explain. \_\_\_\_\_

\_\_\_\_\_ Are you not feeling well because of a temporary illness such as a cold or fever?

Please note: If your health condition adversely changes, tell your exercise leader or health professional. Your health is solely your responsibility and your exercise leader or health professional cannot accept the responsibility for your health.

What is your goal/objective from participating in this program? \_\_\_\_\_

Waiver & Release: I HAVE READ, UNDERSTOOD AND COMPLETED THIS DOCUMENT TRUTHFULLY. ANY QUESTIONS I HAD WERE ANSWERED TO MY FULL SATISFACTION. I AGREE THAT THERE IS RISK TO ANY TYPE OF EXERCISE AND I ASSUME ALL RISK OF INJURY TO MYSELF OR DAMAGE TO MY PROPERTY AND I ACKNOWLEDGE THAT I AM SOLELY RESPONSIBLE FOR MY HEALTH. I, ON BEHALF OF MYSELF AND MY FAMILY, SUCCESSORS, SURVIVORS, HEIRS AND PERSONAL REPRESENTATIVES, UNCONDITIONALLY WAIVE, RELEASE AND DISCHARGE MY EXERCISE LEADERS AND ANY PERSON OR ENTITY ASSOCIATED THEREWITH, FROM ANY AND ALL LIABILITY, CLAIMS, DEMANDS, LOSSES, COSTS, EXPENSES AND DAMAGES WHATSOEVER RESULTING FROM INJURIES SUSTAINED BY ME OR DAMAGE TO MY PROPERTY AS A RESULT OF MY PARTICIPATION IN THIS PHYSICAL FITNESS PROGRAM, INCLUDING, WITHOUT LIMITATION, THOSE RESULTING FROM ACTS OF ACTIVE, PASSIVE OR GROSS NEGLIGENCE.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian (needed if participant is under the age of 18 years): \_\_\_\_\_

Emergency contacts and information:

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone # 1 \_\_\_\_\_ Phone # 2 \_\_\_\_\_

2.. Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone # 1 \_\_\_\_\_ Phone # 2 \_\_\_\_\_

Health insurance carrier \_\_\_\_\_ plan id # \_\_\_\_\_ ins. Coverage phone # \_\_\_\_\_