Registration Form

Date:_____

First Name:_____ **Last Name:**_____

Home Phone: _____ **Cell Phone:** _____

Work Phone: _____ **Date of Birth**: _____

Email: _____ **Height**: _____

Mailing Address: _____

_____

Primary Care M.D Name: _____

Hospital: _____

Address: _____

Case of Emergency Contact: **Name**_____

Phone_____

How did you hear about us? (Please Circle all that apply)

Local Newspaper	**Walk-by**	**Television**	**Next Door**
Direct Mail Postcard	**Drive-by/location**	**Web Search**	**Facebook**

Referred by:_____ **Other:**_____

What are your Health and Fitness Goals? (Please be specific)

_____

_____

_____

If you refer family members, friends, or co-workers that sign up with us, you will receive $100 Visa Gift Card! Please list their name and number, we will call and offer them a Free Trial to come check us out.

Name:_____ **Phone:**_____

Name:_____ **Phone:**_____

Please read the questions carefully and answer each one:

Circle YES or NO.

Checking YES to any of the 7 questions below will require you to get a physician's clearance before starting an exercise program.

Y	N	Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
Y	N	Do you feel pain in your chest when you do physical activity?
Y	N	In the past month, have you had chest pain when you were not doing physical activity?
Y	N	Do you lose balance because of dizziness or do you ever lose consciousness?
Y	N	Do you have a bone or joint problem that could be made worse by a change in your physical activity?
Y	N	Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
Y	N	Do you know of <u>any other reason</u> why you should not do physical activity?

Members signature **Date:**

Fitness Specialist **Date:**

Answer the following questions below; they will help us determine your risk factors

(2 or more Yes answers may result in medical clearance requirement)

Y	N	Heart attack, bypass surgery or sudden death in a first-degree male relative (i.e. brother, father, son) before age 55.
Y	N	Heart attack, bypass surgery or sudden death in a first-degree female relative (i.e. sister, mother, daughter) before age 65.
Y	N	A current cigarette smoker or those who have quit within the last 6 months.
Y	N	A blood pressure at rest at or above 140/90 (confirmed on two separate occasions) or use of blood pressure medication
Y	N	A total blood cholesterol at or above 200 mg/dl or a HDL Cholesterol at or below 35 mg/dl.
Y	N	A fasting blood glucose at or above 110 mg/dl confirmed by measurements on two separate occasions.
Y	N	A body mass index (BMI) above 30 kg/m2 or a waist girth greater than 100 centimeters.
Y	N	A sedentary lifestyle as defined by the failure to accumulate 30 minutes or more of moderate physical activity most days of the week.
Y	N	Any other known chronic illness.
Y	N	Pain or discomfort in the chest, neck, jaw, arms or other areas, that may be due to poor blood flow.
Y	N	Shortness of breath at rest or with mild exertion.
Y	N	Periodic dizziness.
Y	N	Swelling in the ankles.
Y	N	Unusual heartbeat, heart murmur or episodes of rapid heart rate.
Y	N	Previous episodes of blood clot formation.
Y	N	Unusual fatigue with normal activities.

Members signature **Date:**

Fitness Specialist **Date:**

INFORMED CONSENT AND LIABILITY RELEASE

Fit Club For Women are not responsible for lost or stolen articles under any circumstances.

Informed Consent for fitness instruction: The fitness trainer reserves the right to refuse membership or require a physician's authorization for the participation of exercise, based on the participant's individual risk factors as determined by ACSM standards.

I understand that is my responsibility as the participant to practice safe exercise; stay within my target heart rate or appropriate RPE range and include a brief warm-up and cool-down with each session. It also is my responsibility to inform the staff in writing if there is a change in my health status or a change in my medications.

I agree to assume the risk of participation in exercise both in the strength training circuit and the cardiovascular machines (treadmills, arc trainer etc.), and further agree to release and forever discharge Fit Club For Women its affiliates, staff members, and instructors from any and all claims that may result from my injury or death, accidental or otherwise, during, or arising in any way from any program participation.

In signing this liability release, I affirm that I have read this form in its entirety and understand its contents. I also affirm that all of my questions have been answered to my satisfaction.

I understand that Fit Club For Women strongly recommend, in accordance with the American College of Sports Medicine guidelines, a physician consultation for a health screen to determine any precautions or contraindications to exercising prior program participation. This is due to certain risk factors or existing and/or potential medical problems that I have. I wish to waive this right and exercise at my own risk, holding neither Fit Club For Women and its employees or my physician responsible should any situation arise from my participation. I agree to hold harmless Fit Club For Women and its staff members from any and all claims, suits, losses or related causes of action for damages, including but not limited to such claims that may result from the injury or death, accidental or otherwise, during or arising in any way from this program.

Fit Club For Women strives to ensure that its staff maintains the utmost quality and professionalism in every service offered. In consideration of receiving ongoing training and support, you hereby acknowledge that you may be videotaped or audio recorded by Fit Club For Women for safety, quality control and training purposes.

Member's Signature	Date
Parent/Guardian Signature (if member is under 18)	Date
Fitness Specialist	Date