United Fitness Center

Participant Questionnaire

NAME:	HM PHONE #:	DOB:
ADDRESS:		
EMERGENCY CONTACT:	EMERGENCY PHONE #:	
PRIMARY CARE DOCTOR:	EMAIL:	

DO YOU HAVE OR HAVE YOU HAD...	YES	NO	COMMENTS
Do you feel pain in your chest at rest? **OR** during your daily activities or living? **OR** when you do physical activity?	❑ ❑ ❑	❑ ❑ ❑	
Do you lose balance because of dizziness? **OR** have you fallen in the past 12 months?	❑ ❑	❑ ❑	
Do you have Heart Disease or Cardiovascular Disease?	❑	❑	
Have you ever been diagnosed with another chronic medical condition (other than Heart Disease or High Blood Pressure)?	❑	❑	
Are you currently taking prescribed medications for Heart Disease or High Blood Pressure?	❑	❑	
Do you have a bone or joint problem? This includes Arthritis, Osteoporosis, or Back Problems. If yes, please explain _____ _____	❑	❑	
Have you had a joint replaced? **OR** have you been advised by your doctor to receive a joint replacement?	❑ ❑	❑ ❑	
Do you have cancer of any kind?	❑	❑	
Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes	❑	❑	
Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure	❑	❑	
Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event	❑	❑	
Do you have any other medical condition not listed above? If yes, please explain _____	❑	❑	
Have you exercised regularly in the past 12 months?	❑	❑	

What do you hope to achieve by starting an exercise program? _____

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Revised 11/29/2021

United Fitness Center

Informed Consent and Release Form

I acknowledge that I have chosen to participate in the open gym, personal training and/or group fitness classes held at the United Fitness Center. I further understand that complications may arise during exercise. While these complications are rare, they may include:

- Abnormal blood pressure
- Heart rhythm changes
- Chest discomfort (angina)
- Heart Attack
- Stroke
- Respiratory arrest
- Death

The United Fitness Center has trained staff to deal with an emergency. I understand, that the outcome in an emergency situation cannot be guaranteed if one should occur.

It is my job to report:

- Chest pains while at rest and/or during exertion
- Dizziness or unusual fatigue
- Diabetes (symptoms of low or high blood sugar)
- Any unusual symptoms before, during, or after exercise

I agree to follow the United Fitness Centers rules, including the completion of a pre-activity health questionnaire prior to participation. I acknowledge that the center will obtain a physician clearance in the event the answers on the questionnaire indicate that I should not participate in a program of physical activity without a physician clearance. Furthermore, I understand that group fitness activities outside of the Fitness Center may be unsupervised and I assume all liability for participation.

I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the above mentioned program. I represent and warrant that I have no medical condition that would prevent my participation in the program.

Privacy Notice: The information on this document will not be shared with non-District 304 personal without your consent.

I have read and understand this waiver and the assumption of risk. I understand the risk involved with exercise and I desire to participate at the fitness center, and assume personal responsibility for my health and safety while participating in this program. I further release United General District 304 from any health problems or injuries that may occur as a result of my participation in this program.

In signing my name below, I have given my consent and release as described above. I voluntarily consent to taking part at the United Fitness Center and I understand that I may withdraw from the program at any time.

Print Name_____

Signature_____

Date_____

Witness_____

UNITED GENERAL DISTRICT 304

Building Healthier Communities

Revised 11/29/2021