

BOTH SIDES OF THIS FORM MUST BE COMPLETED BEFORE PARTICIPATING

ONslow COUNTY SENIOR SERVICES

Group Fitness Class Registration

Please print clearly and complete all blanks

Name: First _____ MI _____ Last _____

Address (street): _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

DOB: _____ Race: _____ Sex: _____ Marital Status: _____ County: _____

Military Retiree _____ Military Dependent _____ Military Active Duty _____

Equipment Orientation completed _____ Yes _____ No Date completed _____

Emergency contact: (Each participant must have at least one emergency contact)

Name: _____ Phone: _____ Relationship: _____

List all medications: _____

Activities Participation
_____ Hall Walking
_____ Aerobics
_____ Pilates
_____ Chair Exercise
_____ AFEP
_____ Abs
_____ Strength Training
_____ Line Dancing

Do you now, or have you had in the past:	YES	NO
1. Heart attack	_____	_____
2. Stroke	_____	_____
3. High blood pressure	_____	_____
4. High cholesterol	_____	_____
5. Diabetes	_____	_____
6. Known heart disease	_____	_____
7. Heart murmur	_____	_____
8. Chest pain with exertion	_____	_____
9. Irregular heart beat/rhythm	_____	_____
10. Lightheadedness/fainting	_____	_____
11. Emphysema	_____	_____
12. Asthma	_____	_____
13. Back pain: upper middle lower	_____	_____
14. Other joint pain (explain)	_____	_____
15. Muscle pain/injury	_____	_____
16. Difficulty with physical exercise	_____	_____
17. Recent surgery (last 12 months)	_____	_____
18. Breathing/lung problems	_____	_____
19. Osteoarthritis or rheumatoid arthritis	_____	_____
20. Do you currently smoke # of packs _____	_____	_____

If yes, please explain: _____

Agreement and Liability Release

I do hereby waive, release, and discharge Onslow County Senior Services, and its employees, representatives, or any other individuals acting in their behalf of any and all responsibility or liability from injury and damage resulting from my participation in fitness/exercise activities or in the use of any equipment in their facilities.

I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, are a potentially hazardous activity. I also understand that fitness activities involve a risk of injury and that I am voluntarily participating in these activities and with equipment with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks or injuries that may occur.

I do hereby acknowledge that I have been informed of the need of a physician's approval for my participation in an exercise/fitness activity and with the use of the exercise equipment. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and the use of exercise and training equipment so that I might have his/her recommendations concerning these fitness activities and equipment use. I acknowledge that I have had a physical examination and been given my physician's permission to participate in any or all activities unless otherwise stated by my physician.

Print Name _____

Signature _____

Fitness Instructor Signature _____

Date _____

Onslow County Senior Services

4024 Richlands Hwy Jacksonville, NC 28540 Phone: 910-455-2747 Fax: 910-455-0781

PHYSICIAN'S RELEASE FORM

I have examined _____, on _____
Client's name Date of exam

I have found the following:

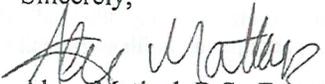
1. _____ She/he may participate fully in a physical activity program consisting of cardiovascular, strength and flexibility training without limitation.
2. _____ She/he may participate fully in a physical activity program with the following limitations, please include a list of contraindicated exercises.
3. **PLEASE INDICATE:**
If patient is on any medication that may affect the heart rate or blood pressure response to exercise.

Physician's Signature: _____ Date: _____

PLEASE NOTE: This record must be STAMPED with a physician's official stamp or be accompanied by a type letter on a physician's letterhead, documenting that a medical evaluation has been performed on the name client and specifies questions 1, 2, and 3 above. Only original color forms will be accepted, unless faxed to or received from physician's office by our Senior Center staff.

Thank you for your help and concern for your patients

Sincerely,


Alexa Matlock B.S. Exercise Science
Fitness Instructor

OCSS STAFF ONLY:

FAXED TO PHYSICIAN OFFICE ON _____ STAFF NAME/SIGNATURE _____