



PROVIDENCE WELLNESS CENTER

RELEASE FORM

LAST NAME

FIRST NAME

I understand and agree that my use of all activities at Providence Wellness Center located at 1200 Providence Road is undertaken at my sole risk and responsibility. I hereby release, indemnify, and hold harmless Providence Wellness Center and Providence Medical Center, and their officers, directors, partners, agents, employees, and successors and assigns from and against any and all liabilities, claims, damages, losses, causes of action, judgment, costs, and expenses, including but not limited to attorneys' fees, as a result of any bodily injury/death and/or property damage which I may experience relative to my usage of the Wellness Center.

I understand and agree that Providence Wellness Center shall not be responsible or liable to me for any articles which are damaged, lost or stolen in or about the Wellness Center or lockers located therein or any loss or damage to any personal property.

I understand that it is recommended that I have a thorough physical examination prior to my use of Providence Wellness Center and/or indicated as such on the 'Pre-participation Screening Questionnaire'. I understand that if I am experiencing a fever, vomiting, or diarrhea, I should not exercise until I have been symptom-free for at least 24 hours. I also understand that if I feel dizzy or lightheaded, I should wait until my symptoms have fully resolved before participating in exercise activities.

I understand and authorize Providence Wellness Center to obtain medical attention and/or services for me in the event I experience any adverse physical signs or symptoms and release Providence Wellness Center from any liability or claim relative to their obtaining these services.

I understand and agree to read and follow all instructions for proper equipment usage and to abide and follow all rules and regulations of the Providence Wellness Center as may be adopted from time to time, and that my failure to comply may result in the suspension of my privileges to utilize the Wellness Center.

Membership Payment

☐

Pay in full. By paying in full at the time of enrollment, I understand this is a one-year contract and will expire 12-months on the date I sign up. If I choose to end my contract early, I understand that I will be required to notify PWC in person or by phone, and I will not be reimbursed for the remaining time of the contract.

☐

Monthly Auto-Pay. I acknowledge that all automatic withdrawals will be set up to a debit or credit card I assign and will be automatically withdrawn monthly on the date I sign up. I understand that this is a one-year contract and will expire 12-months after the date of purchase. If I choose to end my contract early, I understand that I will be required to notify PWC in person or by phone before payments will be stopped.

Participant Name (Please Print)

Date

Participant Signature

PRE-PARTICIPATION SCREENING QUESTIONNAIRE

Date: _____

Name: _____
(Last) (First) (Middle I.)

Address: _____
(Street/RR./Box) City Zip

Cell #: _____ Home #: _____

E-mail: _____

Sex: M _____ F _____ Birth date: ____/____/____ Age: _____

Height: _____ Weight: _____

Assess your health needs by marking all *true* statements:

History

You have had:

- ____ A heart attack
- ____ Heart surgery
- ____ Cardiac catheterization
- ____ Coronary angioplasty (PTCA)
- ____ Pacemaker/implantable cardiac Defibrillator/rhythm disturbance
- ____ Heart valve disease
- ____ Heart failure
- ____ Heart transplantation

**If you have marked any of the statements in this section, consult your healthcare provider before engaging in exercise.*

Symptoms

- ____ You experience chest discomfort with exertion
- ____ You experience unreasonable breathlessness
- ____ You experience dizziness, fainting, blackouts
- ____ You have musculoskeletal problems
- ____ You have concerns about the safety of exercise
- ____ You take prescription medication(s)
- ____ You are pregnant
- ____ You take heart medications

Cardiovascular risk factors

- ☐ You are a man older than 45 years
- ☐ You are a woman older than 55 years or you have had a hysterectomy or you are postmenopausal
- ☐ You smoke
- ☐ Your blood pressure is greater than 140/90
- ☐ You don't know your blood pressure
- ☐ You take blood pressure medication
- ☐ Your blood cholesterol level is >240 mg/dL
- ☐ You don't know your cholesterol level
- ☐ You have a close blood relative that had a heart attack before age 55 (father or brother) or age 65 (mother or sister)
- ☐ You are diabetic or take medicine to control your blood sugar
- ☐ You are physically inactive (i.e., you get less than 30 minutes of physical activity on at least 3 days per week)
- ☐ You are more than 20 pounds overweight

**If you marked two or more of the statements in this section, you should consult your healthcare provider before engaging in exercise.*

☐ None of the above is true.

You should be able to exercise safely without consulting your healthcare provider.

Please list any medications that you use:

Have you been diagnosed with Osteoporosis? Y_____ / N_____.

What goals do you want to accomplish when starting this exercise program?

Have you been a member here before? Y_____ / N_____.

Tell us how you found out about us:

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Y_____ / N_____ Signature_____