PROVIDENCE WELLNESS CENTER

RELEASE FORM

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 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.

Automatic Withdrawal Yearly Membership Contract:
I acknowledge that all automatic withdrawal yearly memberships will be set up to a debit or credit card I assign and will be automatically withdrawn monthly on the date I sign up.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

LAST NAME

FIRST NAME

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____

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