



INFORMED CONSENT AND ASSUMPTION OF RISK FORM

Name: _____

Address: _____

Phone: _____ **Age:** _____ **Sex:** _____

I have volunteered to participate in the Goodman-Rotary Senior Fitness Program. The possibility of certain injuries during exercise does exist including: sprains and falls resulting in broken bones. The possibility of certain other unusual changes during exercise does exist which include: abnormal blood pressure, fainting, disorders of heart beat and very rare instances of heart attack. Effort will be made to minimize these risks by observations during exercise programs. I hereby acknowledge and accept these risks.

By registering or participating, the registrant understands that individual accident insurance is not provided by MSCR programs and agrees to adhere to program rules. I do hereby, for myself, my heirs, executors, and administrators, waive, release, and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in MSCR programs. I further understand that no responsibility is assumed by the leaders of the program or sponsoring agency (s).

Signature

Date



MEDICAL HISTORY FORM

(To be filled out by participant)

Name: _____ Birth Date: _____ Date: _____
Address: _____ City: _____ Zip: _____
Home Telephone #: _____ Work Telephone #: _____
Physician: _____ Medications: _____
In case of emergency contact: _____ Phone #: _____
Height: _____ Weight: _____ Recent weight loss/gain: _____

PLEASE CHECK IF YOU HAD/HAVE ANY OF THE FOLLOWING:

- | | |
|---|--|
| <input type="checkbox"/> Difficulty with hearing | <input type="checkbox"/> Diagnosed cancers |
| <input type="checkbox"/> Difficulty with vision | <input type="checkbox"/> Any orthopedic injuries |
| <input type="checkbox"/> Rheumatic fever or heart murmur | <input type="checkbox"/> Arthritis – Type _____ |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Joint Replacements ____ Hip ____ Knee |
| <input type="checkbox"/> Irregular heart beats | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diabetes: At what age? _____ | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Asthma or other lung problems | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Heart attack, stroke, angioplasty, bypass surgery or blood vessel surgery. At what age? ____ | |

RISK FACTORS

- Borderline or high blood pressure
- High cholesterol or triglycerides
- Family history of heart disease, stroke or carotid artery surgery in parents or siblings prior to the age of 55

SMOKING HISTORY

____ Current smoker ____ packs a day ____ Stopped: What date ____ ____ Never smoked

Have you experienced any of the following while exercising?

<input type="checkbox"/> Balance problems	<input type="checkbox"/> Irregular or rapid heart beat
<input type="checkbox"/> Chest pain or tightness	<input type="checkbox"/> Episodes of dizziness or fainting
<input type="checkbox"/> Labored or difficult breathing	<input type="checkbox"/> Joint pain in _____

List any existing/current health concerns:

