

Wellness Exercise Program Health History

Name: _____

Date: _____

Medications: _____

Drug allergies: _____

Health History - check the appropriate boxes:

Do you have a history of:	Yes	No
Heart disease		
Chest pain		
High blood pressure		
Dizziness		
Lung disease		
Shortness of breath		
Diabetes		
Arthritis		
Obesity		
Muscle, bone, joint pain/injury		
Other:		

**** If you answered YES to one or more, please obtain medical clearance from your physician before beginning an exercise program.*

Other information that would be pertinent to your participation in the program:

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

Name: _____

Date: _____

Signature: _____

Witness: _____

Wellness Exercise Program

Name: _____

Phone: H/ _____

Address: _____

Phone: W/ _____

DOB: _____

Sex: M F

Physician: _____

Phone: _____

Emergency Contact Person: _____ Phone: _____

**Wellness Exercise Program
Consent and Release Statement**

I, _____, desire to engage voluntarily in the Wellness Exercise program at the Medical Center of Lewisville.

I understand that I am fully responsible for safe operation of equipment and if I have any questions regarding equipment or equipment usage, I will ask the staff.

I understand that the hours of operation are TTH 6:30 a.m. - 11:30 a.m. and that I must check IN and OUT with the staff each time I use the facilities.

I understand and I am fully comfortable with self-monitoring techniques and will incorporate safe exercise techniques each time I am using the facility.

I have been informed that I must obtain a physician's release to participate in the exercise program.

I hereby release Medical Center of Lewisville and their officers, directors, employees and agents from any and all liability arising from or in any way connected with the exercise program. I understand that the exercise program will be geared toward the capabilities and physical fitness of adults. However, it will be solely my responsibility to determine my individual level of tolerance, endurance, and participation. I acknowledge the limitations place on my activity by my physician, and I fully understand these limitations.

I HAVE READ AND I UNDERSTAND THE ABOVE PARAGRAPH. I HAVE HAD AN OPPORTUNITY TO ASK ALL QUESTIONS THAT HAVE OCCURRED TO ME AND ALL HAVE BEEN ANSWERED TO MY SATISFACTION I HEREBY CONSENT TO THESE TERMS AS A CONDITION TO PARTICIPATE IN THE EXERCISE PROGRAM AND SO INDICATE BY AFFIXING MY SIGNATURE BELOW.

Signature

Date

Witness

Date

Release of Confidentiality

I, _____, by signing this form, am giving permission for my exercise flow sheet, which has my name, both first and last, to be out on the maintenance exercise group table in the gym while the facility is open. I also am giving my permission to have my name, both first and last, to appear on an attendance list that will be at the staff workstation while the facility is open.

I understand that anyone will have access to my personal information in my absence from the gym. Neither I, nor my family, will hold the Cardiac Rehabilitation staff, any employee of Medical Center of Lewisville, or the Medical Center of Lewisville Hospital responsible for any consequences that may arise out of this action.

(Printed Name)

Date

(Signature)

Date

(Witness)

Date