Castle Medical Center
Wellness & Lifestyle Medicine
Adventist Health

updated 2013/10

CASTLE FITNESS PROGRAM
Registration Form

Name						Today's Date	
Sex:	☐ M ☐ F	Birth Date:		Age:		Castle Employee?	☐ No ☐ Yes (Dept:_____)
Street Address:						City/Zip:	
Phone:	(Hm)		(C)			(Wk)	
Email Address:						Would you like to receive our Monthly Wellness Calendar?	☐ Yes ☐ No
Physician's Name:						Physician's Phone:	
IN CASE OF EMERGENCY Person to call & Relationship						Phone	

Are you taking any medications or drugs? If so, please list medication, dose, and reason.

Does your physician know you are participating in this exercise program?

Describe any physical activity or exercise program that you do somewhat regularly:

Do you now, or have you in the past had:	Yes	No
1. History of heart problems, chest pain, or stroke	☐	☐
2. Increased/High blood pressure	☐	☐
3. Any chronic illness or condition	☐	☐
4. Difficulty with physical exercise	☐	☐
5. Advice from a physician not to exercise	☐	☐
6. Recent surgery (last 12 months)	☐	☐
7. Pregnancy (now or within last 3 months)	☐	☐
8. History of breathing or lung problems	☐	☐
9. Bone, ligament, or tendon problems	☐	☐
10. Muscle or joint problem (specify: neck, back, shoulder, knee, hip, or other)	☐	☐
11. Diabetes or thyroid condition	☐	☐
12. Obesity (more than 20% over ideal body weight)	☐	☐
13. Increased blood cholesterol	☐	☐
14. History of heart problems in immediate family	☐	☐
15. Hernia, or any condition that may be aggravated by lifting weights	☐	☐

Please explain any "yes" answers:

INFORMED CONSENT AND RELEASE

FITNESS

I, _____, have completed the "Castle Fitness Program Registration" form as thoroughly and honestly as possible. I understand that any physical exercise or use of equipment has the potential for possible injury. I acknowledge that I have been informed of the need to consult my physician about the safety and appropriateness of my participation in aerobic and resistance training exercise activities. 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 use of exercise and training equipment so that I might have his/her recommendations concerning these activities and equipment use. I acknowledge that I have either had a physical examination and have been given my physician's approval to participate, or that I have decided to participate in activity and use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

I RELEASE CASTLE MEDICAL CENTER (HERETOFORE REFERRED TO AS CMC), THE WELLNESS & LIFESTYLE MEDICINE CENTER (A DEPARTMENT OF CMC & HERETOFORE REFERRED TO AS THE WELLNESS CENTER), ITS EMPLOYEES, AGENTS, AND PHYSICIANS FROM ANY AND ALL RESPONSIBILITY OR LIABILITY WHICH MAY ARISE OUT OF MY USE OF THIS FACILITY.

FINANCIAL OBLIGATIONS

I understand that to maintain my Castle Fitness Program (heretofore referred to as CFP) membership, I am required to pay my monthly/quarterly membership fee in order to participate in any of Castle's fitness classes. All dues must be paid prior to commencement of the program and by the first class that I attend of each month/quarter. I understand that I am financially responsible for my membership, and that I may be billed by the Wellness Center or CMC in the case that I am financially negligent.

I understand that there is a one-time membership enrollment fee of $25 due in addition to my CFP monthly/quarterly membership. I understand that if I am not enrolled for 12 months in CFP classes, I need to repay the one-time membership enrollment fee of $25.

CFP membership fees are generally non-refundable after 24 hours of payment. Membership credit will be granted at discretion of the Wellness Center.

CLASS CANCELLATION/CHANGE

I realize that the Wellness Center may cancel or change a class at any time. I understand that I will not receive a refund if this occurs.

CLASS PARTICIPATION

I will conduct myself in an appropriate and considerate manner. If it is determined that I am not doing so, a CFP instructor, the Wellness Center, or CMC may ask me to leave. In this case, I will abide by all terms of participation that are set forth at the Wellness Center's discretion (which may include dismissal from class, the CFP, or the Wellness Center itself).

I understand that CFP classes and schedules are subject to change.

I, _____, have reviewed and agree to the above terms.

Signature: _____ Date: _____