



Town of Webster
Webster Recreation Center
1350 Chiyoda Drive
Webster, New York 14580

I am generally healthy and know of no condition that might prevent me from safely engaging in strength training or cardiovascular program

I have completed a health questionnaire and I understand that the staff of the Webster Recreation Center may require an authorization form from my physician in order to approve my participation in the exercise program.

I understand that there is no physician or any medical representative supervising the Center. I understand the minimal risks involved in participating in an exercise program. Although medical emergencies are rare, I realize the orthopedic, cardiovascular and other medical complications are possible.

I accept all responsibilities for any injury, whatsoever, which I may receive while using the equipment or taking a fitness class.

If an injury occurs, I authorize the person in charge to seek medical care. I will pay the cost of such care. I also release the Town of Webster Parks and Recreation Department and staff from any liability arising out of participation in said programs. I further understand that participation is at my own risk and I assume the risk of injury.

Print Name_____

Signature of Participant_____ Date_____

TOWN OF WEBSTER HEALTH HISTORY QUESTIONAIRE

Name _____ Home Phone _____

Address _____ Cell Phone _____

Name of Emergency Contact _____ Emergency Phone _____

Alternate Emergency Contact _____ Emergency Phone _____

Male _____ Female _____ Date of Birth _____ Weight _____ Height _____

Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. To help us determine if you should consult with your doctor before starting to exercise, please read the following questions carefully and answer each one honestly. All information is kept confidential. Please check YES or NO.

- | YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you have a heart condition? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have you ever experienced a stroke? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you have epilepsy? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have diabetes? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Do you have emphysema? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you feel pain when you engage in physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have bronchitis? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. In the past month, have you had chest pain when you were NOT doing physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you ever lose consciousness or do you ever lose control of your balance due to chronic dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Are you currently being treated for a bone or joint condition that restricts you from engaging in physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Has a physician ever told you, or are you aware that you have high blood pressure? |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Has a physician ever told you, or are you aware that you have a high cholesterol level? |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Has anyone in your immediate family (parents/brothers/sisters) had a heart attack, stroke, or cardiovascular disease before age 55? |

15. List any known allergies, including latex allergy.

List date of last Physical Exam _____

Name of Physician _____

Phone Number of Physician _____

I verify that I have answered these questions truthfully and to the best of my knowledge. If I have a change in my health status during the course of my exercise program, I will notify the Fitness staff immediately.

PRINT NAME _____

SIGNATURE _____

DATE _____