

CONSENT FORM
HESS FITNESS CENTER
MEMORIAL HOSPITAL, INC.
McPHERSON, KS

Name _____ Date _____

Address _____

Street

City

Zip

Birthdate _____ Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

In Case of Emergency, Notify _____

Name

Relationship

Phone Number

SHOULD YOU CONSULT A DOCTOR BEFORE EXERCISING?

There are some risks that are associated with an exercise program. The following questions are designed to help identify any potential risk areas that should be re-evaluated by your doctor before you participate in a fitness program. Each applicant is required to satisfactorily answer the following questions, to attest to the truth and accuracy of the answers and to give a limited release to the HESS FITNESS CENTER.

I. SUSPECTED CORONARY DISEASE:

A. Have you ever been advised by a doctor to avoid exercise? YES NO

Explain: _____

B. Do you have angina pectoris (chest pain)? YES NO

C. Have you ever had an electrocardiogram taken while you were exercising (steps, bicycle, treadmill) which the physician felt was abnormal? YES NO

D. Have you ever had pain, pressure, or a squeezing feeling in the chest during or immediately after exercising, walking, climbing stairs, or any other physical activity? YES NO

E. As a result of walking several blocks, have you ever or do you now experience severe pain in your calf (lower leg) which subsides with rest? YES NO

II. HIDDEN HEART DISEASE:

A. Has your doctor ever told you that you had definite or suspected heart trouble of any kind? (i.e. heart murmurs, rheumatic fever, heart attack, coronary occlusion or thrombosis, enlarged heart, congestive heart failure, heart block, irregular rhythm) YES NO

B. Have you ever had bouts of rapid heart beat, irregular heart beat, or palpitations for no apparent reason? YES NO

III. SYMPTOMS:

- A. Do you often feel faint or have spells of severe dizziness? YES NO
- B. Do you experience shortness of breath or difficulty in breathing with mild exertion? (ex: when climbing stairs) YES NO
- C. Have you ever had any back problems, or has your doctor ever said you have orthopedic problems (bone, ligament, tendons, joint or muscle) such as arthritis, tendonitis, or bursitis which would prevent you from doing strenuous physical work? YES NO

IV. PRIMARY CARDIOVASCULAR RISK FACTORS:

- A. 1. Are you CURRENTLY a cigarette smoker? YES NO
Average number of cigarettes per day? (not packs) _____
2. If you are a FORMER cigarette smoker, was it less than two years ago that you quit? YES NO

What was your average number of cigarettes smoked per day?
(Not Packs) _____
When did you quit? _____

- B. Do you, or have you ever had a lung or breathing problem? YES NO
(Asthma, chronic bronchitis, emphysema) If so, explain: _____

V. PRIMARY RISK FACTORS

- A. Do you have diabetes mellitus (hyperglycemia i.e. high blood sugar)? YES NO
If YES, circle A, B, or C
A. Under age of 40 controlled by insulin.
B. At or after age of 40 controlled by insulin or pills
C. Controlled by diet or diabetes onset after age of 55

- B. Do you have high blood pressure (hypertension)? YES NO
If so, are you presently taking medication to lower your blood pressure?
If so, what kind? _____

- C. Does your present diet consist of consuming less than 1200 calories per day? YES NO

VI. PHYSICAL RISK FACTORS

- A. Are you pregnant? Or, have you been recovering from delivering a child, in less than six weeks? YES NO
- B. Do you, or have you recently had any injuries or surgeries (including minor)? YES NO
Please List: _____

****** IF YOU HAVE ANSWERED YES ON ONE OR MORE OF THE ABOVE ITEMS, ****
YOU MUST HAVE THIS FORM SIGNED BY YOUR DOCTOR BEFORE BEING ASSESSED AND
STARTING YOUR EXERCISE PROGRAM.**

THE ASSESSMENT

On the day of your assessment this medical history/ consent form must be completed (signed by physician if necessary) and returned with your payment. The following tests will be performed during the first part of your assessment. Some items may be excluded depending upon any risk factors you have:

- Blood Pressure
- Body Composition (fat and lean mass)
- Weight/ Height/ Frame size
- Step Test (3 min/bench)
- Flexibility (hamstring, lower back)
- Upper and lower body strength (weights)
- Lung capacity (submaximal)
- Abdominal strength and endurance

The second part of your assessment may include a prescribed program of aerobic conditioning, abdominal work, and strengthening or toning with weights, based upon your test results and goals.

You may experience some muscle soreness after completing your assessment, depending upon your present fitness level. This is normal and should go away within a couple of days.

If you follow the program prescribed for you with a regular, dedicated consistency, you may see gradual improvement in body fat loss, endurance, flexibility and strength.

RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AGREEMENT

IN CONSIDERATION of being permitted to benefit from the programs of the Hess Fitness Center (“Fitness Center”) owned and operated by Memorial Hospital, Inc/ and to use its equipment, the undersigned, hereby acknowledges, agrees, and represents that he or she has, or will, inspect and carefully consider such premises’ equipment and facilities. It is further warranted that each entry into the Fitness Center for observation or use of any facilities or equipment or participation in such program constitutes an acknowledgement that such premises and all facilities and equipment thereon and such affiliated program have been carefully considered and that the undersigned finds and accepts same as being safe and reasonably suited for the purpose of such observations, use or participation.

1. **THE UNDERSIGNED HEREBY RELEASES, WAIVES AND DISCHARGES** Memorial Hospital, Inc. its trustees, officers, and agents (hereinafter referred to as “Hospital”) from all liability to the undersigned, personal representatives, assigns, heirs, and next of kin for any loss or damages on account of injury to the person or property or resulting in death of the undersigned, whether caused by the negligence of the Hospital or otherwise while the equipment is in , upon, or about the premises or any facilities or equipment therein or participating in any program affiliated with the Fitness Center.
2. **THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND SAVE AND HOLD HARMLESS** the Hospital from any loss, liability, damage or cost they may incur due to the presence of the undersigned in, upon, or about the premises or in anyway observing or using any facilities or equipment of the Fitness Center or participating in any program affiliated with the Fitness Center whether caused by the negligence of the Hospital or otherwise.
3. **THE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RICK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE** due to negligence of Hospital or otherwise while in, about or upon the premises of the Fitness Center and/or while using the premises or any facilities or equipment thereon or participating in any program affiliated with the Fitness Center.
4. Undersigned acknowledges that children under 16 years of age are not allowed in the Fitness Center and a person must be at least 16 years of age to participate.

THE UNDERSIGNED further expressly agrees that the Foregoing **RELEASE THE WAIVER AND INDEMNITY AGREEMENT** is intended to be as broad and inclusive as is permitted by the laws of

the State of Kansas and that is any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

THE UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THE RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AGREEMENT, and further agrees that no oral representations, statements, or inducement apart from the foregoing written agreement have been made.

If you are under 18, a parent or legal guardian must read and sign below

By signing as a parent or guardian of a participant under 18 years of age, you agree to the above terms on behalf of the minor and agree that the minor and anyone acting on behalf of the minor shall be bound by such terms and conditions.

I HAVE READ THIS RELEASE. THIS RELEASE REMAINS EFFECTIVE FOR AN INDEFINITE PERIOD OF TIME.

SIGNATURE _____ DATE: _____

Print Name: _____

PHYSICIAN please review "THE ASSESSMENT" at the top of the page and note any limitations you may have for your patient regarding the testing or exercise:

Physician's signature of approval

Date