The Fitness Center

UW Medicine
VALLEY
MEDICAL CENTER

Please complete and return in person at time of sign-up / orientation, or by:
Fax: 425.656.5356
Mail: The Fitness Center, M/S TPC-043
PO Box 50010, Renton, WA 98058-5010;
Email: FitnessCenter@valleymed.org

ENROLLMENT

Name_____ Date_____

Mailing Address_____City_____Zip_____
E-mail Address _____
Home Phone (____) _____ Work Phone (_____) _____(ext)_____
Cell Phone (_____) _____ Sex: M F Date of Birth: _____
Employer: _____ Department: _____
Person to Notify in Case of Emergency: _____ Phone: _____
Have you participated in Cardiac Rehab, Pulmonary Rehab or Physical Therapy at Valley Medical Center within the last 6 months? _____ Are you a member of GoldenCare at Valley: _____

Type of membership category:

Full:	Therapeutic:	Corporate:
_____ Individual	_____ Stress Free Class	____ VMC Employee
_____ Family Member of full member	_____ Prenatal	____ VMC Volunteer
	_____ Supervised Adult Fitness	____ Physician Group
	_____ Family Member of this group	____ Other Corporate Group
		____ Family Member this group

How did you find out about us? (Check all that apply)
_____ Other member (name) _____ _____Past Member
_____ Doctor (name) _____
_____ VMC magazine
_____ Hospital reader board
_____Walk-by _____Internet Other, please specify _____
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Medical History:

I. A. HAVE YOU EVER HAD OR HAVE NOW:

**___ Heart Attack (Date:_____)
**___ Coronary Bypass Surgery (Date _____)
**___ Congestive Heart Failure
**___ Angioplasty/Stent (Date _____)
**___ Angina/Chest Pain-please explain: _____
**___ Other Heart Problems-please explain: _____
**___ Stroke (Date _____)
**___ Diabetes - Using Insulin
**___ High Blood Pressure –currently higher than 180 systolic or 110 diastolic
___ None of the above

Date of Last Treadmill: _____
___ Moderate or severe asthma or lung disease
___ Recent Surgery (6 months or less) _____
___ Currently Pregnant (Due Date) _____

If you checked any of the above, **a Medical Clearance form filled out by your doctor is required**.
**** A maximum Treadmill test done within the last 12 months is highly recommended for these conditions.**

CONTINUED ON BACK.

B. HAVE YOU EVER HAD OR HAVE NOW:

___ Arthritis
___ Fibromyalgia
___ Multiple sclerosis
___ Cigarette smoking ___ Now ___ In past
___ Shortness of Breath - please explain: _____
___ Physical Disability - please explain:
_____
___ Orthopedic condition - please explain: _____
___ Other medical problems that may limit your exercise - please explain:
_____
_____

___ Back problems
___ Diabetes - not using insulin
___ High cholesterol (Level _____)

List medications:
Name _____Purpose_____
_____ _____
_____ _____
_____ _____

Name of all Physicians: _____ Phone: _____

_____ _____

_____ _____

I verify that this information is correct to the best of my knowledge.

Signature: _____

LIABILITY RELEASE

I, _____ (printed name), wish to participate in exercise and/or fitness activities at or through the Fitness Center at Valley Medical Center.

I agree to release and hold harmless King County Public Hospital District #1 (d/b/a Valley Medical Center), its officers, directors, employees, and agents, from any and all liability for any claims or damages that may arise from my participation in the Fitness Center, including but not limited to personal injury of any kind.

- I understand that exercise and fitness activities may stress the heart, lungs, cardiovascular and circulatory systems, muscles, joints, ligaments and tendons, potentially causing injury and illness, including serious illness such as heart attack. I understand that I may and should stop any Fitness Center activity (including, but not limited to fitness testing activities) at any time if I experience discomfort or pain.

- I have read "Recommended Guidelines for Physician Referral Before Starting an Exercise Program." I understand that I should consult with my physician with respect to any past or present injury, illness, cardiovascular problem, musculoskeletal problem, joint problem, or any other condition or medication that may affect my ability to participate in and endure fitness and/or exercise assessments or activities.

- I understand that 1) there will be no lifeguard on duty in the swimming pool area; 2) the floor in the locker room and pool may be wet and I should use caution and wear water shoes in these areas; 3) there will be no direct supervision of the gym and exercise areas; 4) fitness testing programs do not offer of constitute medical diagnosis; and 5) Fitness Center activities do not constitute medical treatment.

- I agree to follow all guidelines, rules, and instructions for use of the Fitness Center facilities, equipment, and supplies. I will not use a piece of equipment of engage in any Fitness Center activity unless I am familiar with its proper use and comfortable with my knowledge of that equipment or activity.

- I specifically acknowledge the following: (Please check all that apply.)

____ I understand that because I am over 40 years of age, I should have a medical evaluation before I increase my physical activity or take sub maximum fitness tests.
____ I have or may have one or more risk factors or symptoms described in the "Recommended Guidelines for Physician Referral Before Starting an Exercise Program." I understand that I should consult with my physician and obtain medical evaluation before engaging in nay Fitness Center activities.
____ I am an employee of Valley Medical Center, and I understand that time I spend in the Fitness Center is not work time, unless I am performing specifically assigned duties at the Fitness Center, within the scope of my employment. I understand that injuries I sustain in the Fitness Center, unless I am on work time, will not be covered by worker's compensation.
____ I, _____(printed name), am the parent or legal guardian of the person named above, who is a minor ___ incompetent person ___. I grant my permission for this child or incompetent person to participate in the Fitness Center, and I am executing this release on my own behalf and on their behalf.

I certify that I understand this Release, and I voluntarily and knowingly execute this Release. This Release is effective throughout the duration of my Fitness Center membership, or, if I am a Fitness Center guest, until I notify the Fitness Center in writing that I am revoking this Release.

_____ _____
Participant's Signature Parent or Guardian's Signature

_____ _____
Witness Signature Printed name of Witness

_____
Date

Guidelines for Physician Referral
Before Starting an Exercise Program
Taken from Guidelines of the American College of Sports Medicine

Although moderate exercise is safe for most individuals, it is desirable to have at least a limited health appraisal before starting an exercise program or performing an exercise test. For others with cardiovascular risk factors, heart disease, or other medical conditions, it may be necessary to have an evaluation. Listed below are the guidelines for screening and the requirements of the Fitness Center.

Major Cardiovascular Risk Factors:

1. High BP: greater than 140 systolic or 90 diastolic
2. Cholesterol level greater than 200
3. Cigarette smoking
4. Diabetes
5. Family history of heart disease developed before age 55
6. Obesity
7. Sedentary Lifestyle

Major Symptoms or Signs of Disease:

1. Pain or discomfort in the chest, neck, arm, jaw, or shoulder
2. Shortness of breath at rest or with mild exertion
3. Dizziness or fainting
4. Ankle swelling
5. Palpitations or fast heart rate
6. Pain in the legs with exercise
7. Known Heart Murmur
8. Unusual fatigue or shortness of breath with usual activities

Recommendations for Apparently Health Individuals:

1. Individuals < age 40 who do not have major risk factors or symptoms can begin a *moderate or vigorous exercise program* without a medical evaluation.
2. It is desirable for men > 40 and women >50 to have a medical exam and exercise test prior to beginning a *vigorous program.*
3. A physician's clearance is not required for apparently healthy individuals for membership at the Fitness Center.

Recommendations for Individuals at Higher Risk – With Risk factors:

1. For individuals with at least 2 major risk factors but no symptoms, it is desirable to have a medical evaluation and treadmill test done prior to beginning an exercise program.
2. Medical clearance may be required by the Fitness Center.

Recommendations for Individuals with Heart disease or Other Medical Conditions:

1. Any person who is under the care of a doctor for a continuing medical problem listed on the enrollment form should have a medical evaluation and will be required to submit a medical clearance form prior to joining the Fitness Center.
2. A maximum treadmill test is highly recommended for any person who has had a heart attack, coronary bypass surgery or symptoms of heart disease.
3. Individuals who experience angina with exercise will not be eligible for membership in the Fitness Center. A referral can be made to Cardiac Rehab.
4. A medically supervised program is recommended for cardiac patients initiating an exercise program; patients with unstable problems; or high risk, symptomatic or chronic disease patients whose physician feels that medical supervision is necessary for safety. A referral can be made to Cardiac Rehab.