



**ENROLLMENT**



Name \_\_\_\_\_  
 Date \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 \_\_\_\_\_

Day Phone (\_\_\_\_) \_\_\_\_\_ ext. \_\_\_\_\_ Evening Phone  
 (\_\_\_\_) \_\_\_\_\_

Sex: M F Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married

Employer: \_\_\_\_\_  
 Department: \_\_\_\_\_

Person to Notify in Case of Emergency: \_\_\_\_\_  
 Phone: \_\_\_\_\_

Have you participated in Cardiac Rehab, HMR 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 Employ
____ Family Member	____ Prenatal	____ VMC Affiliat
of full member	____ Supervised Adult Fitness	____ VMC Volunte
	____ Family Member of this	____ Physician Gro

	group	_____ Other Corpora
		_____ Family Memb

List Your Household Family Members:

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did another member at the Fitness Center refer you for membership? \_\_\_\_\_

If so, who? \_\_\_\_\_

=====

**Medical History:**

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

\*\* \_\_\_ Heart Attack (Date: \_\_\_\_\_)

Date of Last Treadmill: \_\_\_\_\_

\*\* \_\_\_ Coronary Bypass Surgery (Date \_\_\_\_\_)

\*\* \_\_\_ Angioplasty/Stent (Date \_\_\_\_\_)

\*\* \_\_\_ Congestive Heart Failure

\*\* \_\_\_ Stroke (Date \_\_\_\_\_)

\*\* \_\_\_ Diabetes - Using Insulin

\_\_\_ Moderate or severe asthma or lung di

\*\* \_\_\_ Angina/Chest Pain-please explain: \_\_\_\_\_

\_\_\_\_\_

\*\* \_\_\_ Other Heart Problems-please explain: \_\_\_\_\_

\_\_\_\_\_

\*\* \_\_\_ High Blood Pressure -Currently higher than

180 systolic or 110 diastolic

\_\_\_ Recent Surgery-please explain: \_\_\_\_\_

\_\_\_ Pregnancy (Due Date: \_\_\_\_\_)

\_\_\_ None of the above

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
  - Back problems
  - Fibromyalgia
  - Diabetes - not using insulin
  - Multiple sclerosis
  - High cholesterol (Level \_\_\_\_\_)
  - 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: \_\_\_\_\_
- 

**List medications:**

Name	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

Name of all Physicians: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

Signature: \_\_\_\_\_



## Statement of Release from Liability

I, \_\_\_\_\_ (print), hereby acknowledge that I have read the recommended medical guidelines for screening into an exercise program. I understand the information therein relative to my participation in the Fitness Center at Valley Medical Center.

In recognition of my desire to participate in a physical fitness program, I hereby consent, voluntarily, to participate in selected exercise assessments and/or activities in the Fitness Center.

I understand that there will be no lifeguard on duty in the swimming pool area or direct supervision of the gym and exercise areas. I agree to follow all guidelines and rules for the use of the facility, equipment, and supplies.

In consideration of my enrollment in the program, I, the undersigned, intending to be legally bound, hereby for myself, my heirs executors, administrator, and or assigns,

waive or release any and all rights and claims for damages I may have against Public Hospital District No. 1 of King County, Washington (Valley Medical Center), its representatives, successors, and assigns, for any and all injuries suffered by me in this program. Further, I hereby agree to hold harmless Public Hospital District No. 1 of King County, Washington (Valley Medical Center) from any claims of third parties arising out of my participation in this program.

**Check if applicable:**

\_\_\_\_\_ **Over Age 40 Waiver of Medical Referral:** I hereby acknowledge that I have read the recommended guidelines for physician referral into the exercise program. I understand that if I am 40 years of age, I should have a medical evaluation prior to an increase in physical activity or submaximum fitness test.

\_\_\_\_\_ **Valley Medical Employee Release:** I hereby acknowledge that time spent in the Fitness Center does not constitute work time, unless I am performing specifically assigned duties within the scope of my employment at Valley Medical Center. Injuries which occur while in the Fitness Center will not be covered under the Workers Compensation program.

\_\_\_\_\_ **Under age 18 or not legally competent - Statement of Release:** As parent or guardian for the participant named above, I hereby grant my permission for my child or dependent to participate in the Fitness Center programs. I hereby acknowledge the risks and agree to the terms and conditions set forth in the Statement of Release from Liability above on behalf of my child or dependent.

**I ACKNOWLEDGE THAT I HAVE READ THE FOREGOING AND UNDERSTAND ITS CONTENTS.**

Signature of Participant: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

(for members under age 18 or not legally competent)

Witness: \_\_\_\_\_

Date: \_\_\_\_\_