

Fall Winter Spring Summer



Health History Form (2012)

Howell Area Aquatic Center

Anyone with health concerns may be required to provide a doctor's permission before participating in any exercise programs at the Howell Area Aquatic Center

Name: _____ Date: _____

Phone Number: _____ Email: _____@_____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Gender: M F Occupation: _____

In case of emergency please contact: _____ Relationship: _____

Phone number(s): _____

Does your physician know you are participating in this exercise program: Yes or No

Physician's Name: _____ Phone: _____

Please list any medications, dosage, and reason for taking (attach another page if necessary):

Do you now or have you had in the past:	YES	NO
1. History of health problems, chest pain or stroke?	<input type="checkbox"/>	<input type="checkbox"/>
2. Increased blood pressure/ Hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
3. Any chronic illness or condition?	<input type="checkbox"/>	<input type="checkbox"/>
4. Difficulty with physical exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Advice from a physician not to exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Recent surgery (within the last 12 months)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Pregnancy (now or within the last 3 months)?	<input type="checkbox"/>	<input type="checkbox"/>
8. History of breathing or lung problems?	<input type="checkbox"/>	<input type="checkbox"/>
9. Muscle, back disorder, or any previous injury still affecting you?	<input type="checkbox"/>	<input type="checkbox"/>
10. Any bone or joint problems such as Osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>
11. Loss of balance due to dizziness or lack of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
12. Diabetes or thyroid condition?	<input type="checkbox"/>	<input type="checkbox"/>
13. History of heart problems within immediate family?	<input type="checkbox"/>	<input type="checkbox"/>
14. Hernia or any condition that may be aggravated by lifting weights?	<input type="checkbox"/>	<input type="checkbox"/>
15. Seizures of any kind?	<input type="checkbox"/>	<input type="checkbox"/>
16. Allergies? Latex allergy?	<input type="checkbox"/>	<input type="checkbox"/>

Seek the guidance of your physician if you answered yes to two or more of the above questions.

Waiver of Liability/Informed Consent/Media Release Form

I have enrolled in a program of strenuous physical activity including, but not limited to, muscle strength and endurance training, cardiovascular conditioning, aquatic exercises and other various activities offered by Howell Parks & Recreation Department at the Howell Area Aquatic Center. I hereby affirm that I am in good physical condition and do not suffer from any disability which would prevent or limit my participation in this exercise program.

For myself, my heirs and assigns, I hereby release and forever hold harmless the Howell Parks & Recreation Department, Howell Public Schools and its representatives (its employees and owners), from any claims, demands and causes if action arises from my participation in the exercise programs. I assume all risks of injury arising out of my participation in physical activity at the Howell Area Aquatic Center, including my use of any equipment, and I hereby release the Howell Parks & Recreation Department, Howell Public Schools and its representatives (its employees and owners), from any liability now or in the future including, but not limited to heart attacks, muscle strains, pulls or tears, broken bones, shin splints, heat prostration, knee/lower back/foot injuries, drowning, and any other illness, soreness, or injury however caused, occurring during, or after my participation in the exercise program.

I consent to receive medical treatment which may be deemed advisable in the event of injury, accident and/or illness during my participation in exercise classes at the aquatic center.

In order to maximize my own safety, I agree to the following:

To sign in for any class I attend.

To discuss my participation in the class with my medical provider if appropriate.

To share medical provider contact information with instructor if requested.

To follow guidelines set out by the class instructor.

To seek approval from my medical provider if any changes in my physical condition could affect my class participation.

"I hereby release any media including, but not limited to, photographs and videos, in which I may appear at the Howell Area Aquatic Center. Media may be used for the purpose of marketing or advertising."

Signature: _____

Date: _____

I hereby affirm that I have read and fully understand the above and will complete a new Health History and waiver annually or if my medical conditions change.

