

One Human Performance

Registration & Consent Form and Health Questionnaire

Name: _____ Date of Birth: _____
 Day Phone: _____ Eve Phone: _____ Other Phone: _____
 Address: _____ City: _____ State: NJ ZIP: _____
 Email: _____

Session Choice Mon. 6pm Tue. 12pm only Wed. 6pm only Thu. 12pm only Mon/Wed 6pm Tue/Thu 12pm

Program Guidelines

I agree that I will be participating in a group training program that will meet **2x** per week on **Tuesdays & Thursdays** at **6pm** at **Wayne Boys & Girls Club**, and sessions will be **60** minutes in length. The program will run for **8** weeks, from **June 16th** through **August 6th**. The total program fee of **\$148 (two sessions weekly) or \$98 (one session weekly)** will be paid by check payable to “*ONE Human Performance*” prior to the commencement of the first training session. I understand that program fees are non-refundable and credit will not be given for missed sessions.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Has a doctor ever said you have a heart condition and recommended only supervised physical activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have chest pain brought on by physical activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you tend to lose consciousness or fall over as a result of dizziness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has a doctor ever recommended medication for your blood pressure or a heart condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have a bone or joint problem that could be aggravated by the proposed physical activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you aware, through your own experiences or a doctor’s advice, of any physical reason against your exercising without medical supervision? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you over the age of 65 and not accustomed to rigorous exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you currently or have you been pregnant within the last six months? | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered YES to one or more of the questions above, please answer the following questions:

- | | | |
|---|--------------------------|--------------------------|
| 9. Have you consulted your physician regarding increasing your physical activity and/or performing a fitness assessment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. If you answered yes to question 8, will you consult your physician prior to increasing your physical activity and/or performing a fitness assessment? | <input type="checkbox"/> | <input type="checkbox"/> |

Do you now have, have you recently experienced, or have you ever had:
 (Check all those that apply, leave others blank)

- | | |
|--|--|
| <input type="checkbox"/> Heart attack, coronary bypass, or stroke
<input type="checkbox"/> Extra, skipped or rapid heart beats/palpitations
<input type="checkbox"/> Asthma, respiratory problems, pulmonary disease
<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Arthritis, orthopedic problems
<input type="checkbox"/> Ulcer
<input type="checkbox"/> Arteriosclerosis
<input type="checkbox"/> Increased anxiety or depression
<input type="checkbox"/> Fatigue, lack of energy | <input type="checkbox"/> High/Low Blood Cholesterol
<input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> Diabetes
<input type="checkbox"/> HIV or AIDS virus
<input type="checkbox"/> Cancer
<input type="checkbox"/> Neuromuscular disease
<input type="checkbox"/> Bulimia or Anorexia
<input type="checkbox"/> Emotional disorders
<input type="checkbox"/> Trouble sleeping |
|--|--|

By signing below I understand the risks inherent with this event and agree to all program parameters. I do not hold liable One Human Performance Center or any of its representatives or employees. I will notify the proper individuals as to any risk factors and/or medical concerns that may affect my participation.

Parent Name(s): _____

Signature: _____