Please Send to
Wellness Division
Box #44

City of Gainesville Wellness Centers

PRE-PARTICIPATION HEALTH QUESTIONNAIRE

Last Name___________________________ First Name________________________ Dept.____________________

Phone Number (work) _________________ (home/cell) ________________________ Date of Birth __________

Please check ( ) your response to the following questions. If yes, please explain.

Yes No

( ) ( ) 1. Are you currently taking any prescribed or over the counter medications? If yes, please list the medication and its purpose:____
____

a.) Are any of these a beta blocker, heart, or stroke medication? ______________________________

( ) ( ) 2. Has a physician ever told you that you have a heart condition? If yes please explain:
____

( ) ( ) 3. Do you feel pain or pressure in your chest, neck, shoulder(s) or arm(s) during or after physical activity?

( ) ( ) 4. Do you lose your balance because of dizziness or do you ever lose consciousness?

( ) ( ) 5. Has a physician ever told you or are you aware that you have high blood pressure?

( ) ( ) 6. Has anyone in your immediate family (parents, brothers, sisters) had a heart attack, stroke, or cardiovascular disease before age 50?
If yes, please explain: ____

( ) ( ) 7. Has a physician ever told you or are you aware that you have a high cholesterol level?

( ) ( ) 8. Do you currently smoke? For how long and how often? ___________________________________

( ) ( ) 9. Do you have any bone or joint problems that could be made worse by a change in your physical activity? If yes, please explain: ____

( ) ( ) 10. Do you have any physical or medical conditions (e.g. Diabetes, recent surgery, arthritis, pregnancy, etc.) not mentioned above, or do you know any other reason why you should ***not*** engage in physical activity? If yes, please explain:____

( ) ( ) 11. Are you currently exercising *less than* 3 times per week? If not, please list your activities:
____

That fact that you answered "No" to the above questions does not guarantee that you will not have an abnormal response to exercise. All physical activity entails some risk. Always seek City of Gainesville Wellness Centers Staff or call 911 if you experience chest or neck pain, radiating pain on one side of own one arm, severe headache, extreme fatigue, or any other unusual symptoms. If you answered "Yes" to any of these questions, it might be recommended that you obtain your physician's permission to participate. Your file will be reviewed and you will be contacted with further details, please help by being specific with your answers.

____ ____________________
Signature Date

The City of Gainesville Wellness Centers recommend that every participant consult his/her physician before beginning any exercise program, after a lengthy period of inactivity, and/or if your health status changes.

Please Send to
Wellness Division
Box #44

City of Gainesville Wellness Centers

INFORMED CONSENT

I acknowledge that participating in a physical fitness program carries certain risks. These risk include (but are not limited to) abnormal blood pressure, fainting, chest pain, shortness of breath, disorders of heartbeat, and in rare instances, heart attack or death. I acknowledge that it is recommended that I obtain clearance from my personal physician before engaging in any exercise program.

I certify that I have filled out a medical history questionnaire and answered all the questions truthfully. If at any time my medical history changes, I will notify the ***Risk Management*** staff immediately.

In consideration of my participating in any exercise activities associated with ***Risk Management***, I hereby take action for myself, my executors, administrators, heirs, next of kin, successors, and assigns as follows:

A) Waive, Release, and Discharge from any and all liability for my death, disability, personal injury, property damage, property theft or actions of any kind which may hereafter accrue to me or my traveling to and from ***Risk Management*** and its directors, officers, employees, volunteers, representatives and agents.

B) Indemnify and Hold Harmless any entities or person mentioned in this paragraph from any and all entities or person mentioned in this paragraph from any and all liabilities or claims made by other individuals or entities as a result of any of my actions during my participation.

I hereby consent to receive medical treatment, which may be deemed advisable in the event of injury, accident, and/or illness during participation in any ***Wellness*** activities.

This informed consent form shall be construed broadly to provide a release and waiver to the maximum extent permissible under applicable law.

I hereby certify that I have read this document and understand its content.

Print Name: _____________________________ Date: ____________

Signature: ______________________________