MEDICAL INFORMATION SHEET

Participants Name _____ Birthdate: ___/___/_____ Age _____

Street Address: _____ City: _____ Postal Address: _____

Email Address: _____

Phone Number: _____ Cell Number: _____

EMERGENCY INFORMATION

In an emergency, please contact the following:

Name: _____ Home Phone: (___) _____ Cell Phone: (___) _____

Name: _____ Home Phone: (___) _____ Cell Phone: (___) _____

Allergies: _____

Medications: _____

Other Medical Information: _____

Special Conditions: (learning disabilities, physical disabilities)

_____

_____

Health History: Please check any conditions your instructor needs to be aware of:

o Asthma	o Diabetes	o Past/Recent Surgery
o Joint Problems/ Arthritis	o Low Back pain/Sciatica	o Repetitive Strain/Surgery
o Heart Connection	o High Blood Pressure	o High-Stress Anxiety
o Upper Back/ Neck Pain	o Osteoporosis	o Pregnant
o Medications	o Stroke	o Other

Healthy Living Objectives: What is your fitness Wish List? What are your most interested in Achieving? Check all that apply:

o Decrease Body Fat	o Lose Weight	Gain Weight
o Improve Eating Habits	o Increase Strength	o Injury Rehab Prevention
o Improve Cardiovascular Fitness	o Increase Energy	o Increase Muscle Tone
o Athletic Improvement for Sport	o Control Stress	o Improve Flexibility
o Health Education	o Other	

I have read, understood, and completed this questionnaire. Initial _____

Date: _____

Participants Signature: _____

Print Name Here: _____

Address: _____ City: _____ Postal Address: _____

If the participant is under the age of 19 years, please fill out below:

Date: _____

Required Parent's Signature _____

Parent Print Name: _____

Address: _____ City: _____ Postal Address: _____

Name(s) of Minor(s): _____

Relationship to Minor(s): _____