Vista Grande Community Center

Registration Form

Program(s) Registering for:
Please Check all that Apply

☐ Open Gym Basketball ☐ Volleyball

☐ Soccer ☐ Fitness

☐ Other _____

Please Print **Participant Name**

Name:

Address: Telephone No:

City/State: Zip Code:

Employer: Business Phone:

Birthdate: ☐ Male ☐ Female

Do you have any type of medical, physical or mental condition?

☐ **yes** ☐ **no**

If yes fill out medical information

Please Print **Medical Information**

Participant has the following condition:

Current medication taken:

Please Print **Emergency Contact**

Name:

Relationship:

Home phone: Work phone:

Doctor: Insurance Company:

Additional Information

Please Read & Sign

If there are any changes in your health status during the year, you must notify BCPR immediately.

I will **not** hold the BCPR, its staff, including directors, agents, representatives, or employee's responsible for any injuries and liabilities that may occur while participating in any activities held at the community center. I further state that all information provided above is correct to the best of my knowledge.

_____ _____ .

(Parent/Participant Signature) **(Date)**

Bernalillo County Fitness Section
Health History Questionnaire

(To be completed with a Registration Form)

NAME_____ **DATE**_____

EMPLOYEE MEMBER _____ **PUBLIC MEMBER** _____

Regular physical activity is safe for most people. The American College of Sports Medicine Standards indicates that some individuals should check with their doctors concerning their participation in an exercise program. **To help us determine if you should consult with your doctor, read the following questions carefully and answer each one honestly.**

Please check **YES** or **NO**

YES	**NO**	
___	___	1. Do you have a heart condition?
___	___	2. Have you ever experienced a stroke?
___	___	3. Do you have epilepsy?
___	___	4. Are you pregnant?
___	___	5. Do you have diabetes?
___	___	6. Do you have emphysema?
___	___	7. Have you had an asthma attack within the last two years or are you taking asthma medications?
___	___	8. Do you feel pain in your chest when you engage in physical activity?
___	___	9. Do you have chronic bronchitis?
___	___	10. In the past month, have you had chest pain when you were not doing physical activity?
___	___	11. Do you ever lose consciousness or do you ever lose control of your balance due to chronic dizziness?
___	___	12. Are you currently being treated for a muscular-skeletal problem that restricts you from engaging in physical activity?
___	___	13. Has a physician ever told you or are you aware that you have high blood pressure?
___	___	14. Has anyone in your immediate family (parents/brothers/sisters) had a heart attack, stroke, or cardiovascular disease before age 55?
___	___	15. Has a physician ever told you or are you aware that you have a high cholesterol level?
___	___	16. Do you currently smoke?
___	___	17. Are you a male over 44 years of age?
___	___	18. Are you a female over 54 years of age?
___	___	19. Are you currently exercising LESS than 1 hour per week? If you answered no, please list your activities.
___	___	20. Are you currently taking medication for blood pressure or a heart condition?

_____

_____

If you answer, **"YES"** to any one of questions 1-12, or answer, **"YES"** to 2 or more of questions 13-19, we recommend that you receive medical clearance prior to your participation in an exercise program.

I have read, understood, and completed this questionnaire. Any questions that I had were answered to my full satisfaction.

Signature_____ **Date**_____