

**Providence Hospital Wellness Institute
Informed Consent for Group Exercise Program
Participation and Waiver of Claims**

The Wellness Institute of Providence Hospital has made available to you a Group Exercise Program. You have expressed an interest in participating in this Group Exercise Program. This document will help you to understand the various risks associated with such participation so that you will make an informed decision concerning your participation.

OPPORTUNITIES

As a participant in the Group Exercise Program, there are many exercise/recreational opportunities available to you. These opportunities include but are not limited to:

- ◆ Use of the locker rooms and showers (items should not be left in lockers over night)
- ◆ Group Exercise class instruction for: Body Sculpt, Low impact, Cardio Combo, Cardio Flex, High/Low Impact Aerobics, Yoga Flex, Cardio Aquatics, Yoga, Senior Fit, Chair-Robics, Tai Chi, Jazzercise, Kickboxing and any specialty classes.
- ◆ 50% discount on classes if enrolled in the Lean to Wellness Weight Management Program.

RISKS

If you elect to participate in the Group Exercise Program at Providence Hospital or to participate in any of its related programs, your participation will be solely at your own risk. **You are advised to consult with your physician before beginning your participation in Group Exercise.** In addition, if deemed advisable by your physician, you should consult with them on an ongoing basis.

Even consultation with your physician and engaging in regular exercise in no way guarantees against the possibility of adverse occurrence during exercise/recreation sessions or use of other fitness center facilities. Possible risks include, but are not limited to, episodes of dizziness, fainting, muscle cramping, muscle and skeletal injury, sprains and strains, heart attack, stroke or sudden death. Please contact your physician for further details.

HEALTH HISTORY

All Group Exercise participants are required to accurately complete the Medical History form prior to exercise. **Physician's clearance may be required prior to joining if deemed necessary by the information provided.**

CONFIDENTIALITY OF RECORDS

All personal information obtained by the Wellness Institute Staff as part of your admittance into the Group Exercise Program will be kept strictly confidential. It is collected for the exclusive use of the staff. This information will not be given to anyone without your written consent, unless it is necessary to respond to an emergency.

HOLD HARMLESS

As a condition precedent to your right to be a Group Exercise participant, you must sign and return this waiver and release. Please read this form and make sure you fully understand it before signing.

I _____, hereby consent to **VOLUNTARILY PARTICIPATE** in the Providence Hospital Wellness Institute Exercise Program. I agree to hold harmless, indemnify and defend Providence Hospital, its agents, students, instructors and employees from any and all claims, demands, damages, liability, causes of action, expenses, costs and attorneys' fees or otherwise for injuries to myself or others, and for damage to property caused by act or failure to act and resulting from my participation in any Wellness Institute program.

SIGNATURE

In signing this form, you state that you have read and understand the descriptions and risk described herein. Any questions, which have occurred to you, have been raised and have been answered to your satisfaction. I agree notify the Wellness Institute in the event that my health status changes in any way from that indicated on the front of this form.

This Consent and Release shall continue to be effective for future programs unless revoked in writing by me.

Applicant's signature: _____ Date: _____

Health History Form

Last Name	First	MI
Address		
City	State	Zip Code
Day Phone Number	Evening Phone Number	Date
Age: _____ Sex: _____ Height: _____ Weight: _____ Goal Weight: _____		

Please check appropriate conditions which apply to you:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Circulatory Disorders
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Palpitations/Rapid Breath	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Kidney/Liver Disease
<input type="checkbox"/> Cardiac Surgery	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Major/Chronic Illness	<input type="checkbox"/> EKG Abnormalities	<input type="checkbox"/> Cigarette Smoking	<input type="checkbox"/> Bone/Joint Problems
<input type="checkbox"/> Pregnant	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Back Injury
<input type="checkbox"/> Stroke	<input type="checkbox"/> Ankle Swelling	<input type="checkbox"/> Sedentary lifestyle	<input type="checkbox"/> Arthritis/Bursitis
<input type="checkbox"/> Claudication	<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Obesity	<input type="checkbox"/> Seizures
<input type="checkbox"/> Difficult/Painful Breath	<input type="checkbox"/> Recent Injury/Surgery	<input type="checkbox"/> Family History of Coronary Disease (55yo)	
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Exer. Induced Asthma	<input type="checkbox"/> Taking Medication*	<input type="checkbox"/> No Problems

Any recent hospitalization? Yes No

Provide a brief medical history including hospitalization, surgery and explanation of conditions checked above:

Recent EKG? Yes No Date: _____

Results: Normal Abnormal Unsure

***List All Medications** (Name, dosage, purpose)

<p>Exercise History</p> <p>Do you exercise regularly (3+ times/week) Yes No</p> <p><i>Type of Exercise Day/Week Minutes/Day</i></p> <hr/> <hr/> <p>Do you have any exercise limitations? Yes No</p> <p>If yes, please explain:</p> <hr/> <hr/>	<p>Exercise Goals</p> <p>What do you wish to accomplish in a cardiovascular conditioning program?</p> <p><input type="checkbox"/> Weight Control <input type="checkbox"/> Athletic Performance</p> <p><input type="checkbox"/> Change in Body Com. <input type="checkbox"/> General Health</p> <p><input type="checkbox"/> Other _____</p> <p>What do you wish to accomplish in a strength-conditioning program?</p> <p><input type="checkbox"/> Tone Muscle <input type="checkbox"/> Muscular Endurance</p> <p><input type="checkbox"/> Strengthen muscles <input type="checkbox"/> Not Interested in Strength</p> <p><input type="checkbox"/> Activity Performance</p> <p><input type="checkbox"/> Other _____</p> <p>What factors, if any do you foresee as interfering with your exercise plans?</p> <p><input type="checkbox"/> Conflicts with work <input type="checkbox"/> Time/Scheduling Problems</p> <p><input type="checkbox"/> Lack of Motivation <input type="checkbox"/> Transportation</p> <p><input type="checkbox"/> Travel</p> <p><input type="checkbox"/> Other _____</p>
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(Effective 01/01/2008)