Chicopee COA Fitness Program Application

Chicopee COA Fitness Program Application to Participate in the Exercise Program and Assumption of Risk

I wish to participate in the Fitness Program at the Chicopee Council on Aging. I understand these exercise programs are under general supervision of a health and fitness professional. These programs are designed to gradually increase the workload on my cardiovascular and/or musculoskeletal system and thereby improve their functioning.

I understand that there are health risks associated with exercise. Possible injuries or medical disorders, arising out of my participation in the fitness program, such as (but not limited to) heart attack, stroke, sprain, broken bones, torn muscles or ligaments, and in rare instances cardiac arrest can occur. Knowing of these risks, I nonetheless request to participate in the fitness program and assume all the risks associated with my participation in the program. This does not guarantee against any of the described risks actually occurring in my case.

I certify that I have carefully read this form before signing it. I also certify that I have had the opportunity to ask questions about the fitness programs and the associated risks. All my questions have been answered to my satisfaction. I understand that I am free to ask any additional questions that I may have later.

Chicopee residents take priority if space is limited.

Name (print) _____ **Date** _____

Signature _____

Witness _____ **Date** _____

*****This form must be completed yearly*****

Revised 10/2017

Fitness Program Participants

All Fitness Program participants are required to have a completed application, and medical clearance form turned into the nurses before any activity is started.

Clean Shoe Policy

Fitness Program users must change into a 2nd pair of shoes prior to using the Fitness Center (107) and the Exercise Studio (117). Please change into your 2nd pair of shoes in the lobby or in the room changing area.

A clean shoe policy is to help accomplish the paramount tasks of preserving the floor surfaces and equipment in the new center. It will also save the COA and the City a considerable amount of funds that would be needed to resurface the variety of floors and replace equipment prematurely, if we did not have a clean shoe policy. This type of policy is typical at most fitness centers. Thank you.

Chicopee COA Fitness Program Screening Form / Medical Clearance

Last Name _____ First Name _____ DOB _____

Address _____ City_____ State____ Zip _____

Phone _____ Mobile _____ Email _____

Age_____ Female_____ Male_____ Height_____ Weight_____

MEDICAL HISTORY (Please circle the appropriate response)

Have you ever suffered from the following?

- Arthritis / RA / joint pain **YES / NO**
- Asthma / breathing problems **YES / NO**
- Circulation problems **YES / NO**
- Diabetes **YES / NO**
- Dizziness **YES / NO**
- Heart condition / surgery **YES / NO**
- Hernia **YES / NO**
- High blood pressure **YES / NO**
- High cholesterol / triglycerides **YES / NO**
- Knee / hip replacement **YES / NO**
- Liver / kidney condition **YES / NO**
- Lower back pain **YES / NO**
- Pacemaker **YES / NO**
- Pain / tightness in the chest **YES / NO**
- Stroke **YES / NO**
- Thyroid problem **YES / NO**

MEDICATIONS: Please list your current medications below.

_____ _____ _____ _____

_____ _____ _____ _____

Have you had any major injuries / surgery during the last three years? **YES/NO**

If yes, please list _____

- Do you consider your diet to be: **GOOD**___ **ADEQUATE/APPROPRIATE**___ **POOR**__
- How do you rate your stress level? **HIGH**___ **MODERATE**___ **LOW**___
- Do you smoke? **YES/NO** Former Smoker? **YES/NO**
- Are you leading a sedentary lifestyle? **YES/NO**
- How long since you have participated in regular exercise? (at least 30 min three times / week)
  6-12 months **3-6 months** **currently exercising**
- Other information: Please list any other significant medical information you consider important for us to know _____

EMERGENCY: please list a person whom we may contact in case of an emergency.

Name:_____ Phone_____ Relation_____

APPLICANT'S SIGNATURE _____ **DATE**_____

MEDICAL CLEARANCE (Renewable on a yearly basis):

I approve this patient for her/his participation in the Chicopee Council on Aging Fitness Program.

Please, indicate any specific guidelines or limitations for this patient: _____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

PHYSICIAN'S PRINTED NAME: _____ PHONE: _____

Please return to: **Chicopee Council on Aging,** 5 West Main St, Chicopee, MA 01020 Fax: 413-557-6989

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