<u>Comanche Nation Fitness Center</u> <u>Membership Registration</u>

NAME			DOB		GENDER
ADDRESS	Mailing			PHONE	Cell
	City	State	Zip		Home/Work/Other
TRIBAL A	FFILIATION &	ROLL NUMBER	_	CNFC MEMB	SER #:
<u>EMERGEN</u> NAME:	CY CONTACT (I	MUST HAVE)	_	RELATION: PHONE:	

TERMS & CONDITIONS

Comanche Nation Fitness Center and Comanche Nation of Oklahoma are not responsible for any personal belongings left at this facility.

Any items left will be held for one week and then given to local charities.

Locker space is available for day use only and is limited to a first come first serve basis.

Locks are not provided. Any locks left will be removed at member's expense.

Children under the age of 12 years will not be allowed access to weight room or equipment.

Registrant must show a Certified Degree of Indian Blood Card (CDIB), valid state or school identification.

Appropriate footwear (athletic shoes) must be worn at all times while in gym.

Shower shoes (non-skid water shoes or "flip flops") are recommended for shower use.

Weights must be re-racked and machines sanitized after use. Trash/recyclables in proper receptacles. Disorderly conduct will result in permanent ban from facility.

WE RESERVE THE RIGHT TO REFUSE SERVICE TO ANYONE.

By signing below I understand and agree to the above terms and conditions of CNFC.

Signature

Date

Staff Initial

<u>Comanche Nation Fitness Center</u> <u>Membership Registration</u>

Informed Consent Waiver

Member Name:

Member Number:

The undersigned hereby gives informed consent to engage in participating in a variety of activities. All exercise and physical activity sessions will be supervised and monitored by a trained exercise technician or a member of the Fitness Center staff.

These activities may include but are not limited to walking, jogging, running, weight training and callisthenic exercises performed within Fitness Center or with Fitness Center staff.

There exists a possibility that certain detrimental physiological changes may occur during exercise and/or exercise testing. These changes could include muscle soreness, heat-related illness, abnormal blood pressure and in rare instances, a heart attack. If abnormal changes occur, the staff has been trained to recognize symptoms and take appropriate actions including administering CPR and First Aid.

I have read this form and understand that there are inherent risks associated with any physical activity. I also recognize that my workout is voluntary and I hereby absolve the Comanche Nation, the Comanche Nation Fitness Center, and/or staff of Comanche Nation Fitness Center and release them from any and all responsibility in the event of an injury or health-related illness.

I further recognize that any medical care that I may require is my personal and financial responsibility.

Print Name

Signature

Date

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Health History

Past and Present Personal Health History (check all that apply)

Diseases of the heart and arteries	Diabetes
High blood pressure (hypertension	Abnormal ECG or EKG
Low Blood pressure (hypotension)	Angina Pectoris (chest pain)
Epilepsy	Stroke
Anemia	Abnormal chest X-ray
Cancer	Asthma
Other Lung diseases	Orthopedic or muscular problems

If any of the above are checked, please explain further and indicate any recommendations your doctor has made regarding exercise and physical activity.

Level of physical activity (please circle)

	• •	
YES	NO	Are you currently involved in a regular aerobic exercise program such as walking,
		jogging, cycling, swimming, step aerobics, etc.?
YES	NO	Are you currently participating in weight training?
YES	NO	Do you perform stretching exercises on a regular basis?
What k	oest describe	es you level of physical activity during the past 4-6 weeks? (Check one)
	Active	More than 3 miles of fast pace walking plus light physical activity daily)
	Modera	ately Active (Less than 3 miles of walking plus light physical activity daily)

Occasionally Active (Only light physical activity daily)

Inactive (Minimal physical activity/no increase in heart rate)

Please indicate any additional exercise information which you think is important for us to know prior to fitness testing or exercise.

		history (first relation) of heart diseaure, lung disease, or epilepsy?	YES	NO	
Please	circle appro	priate answer:			
YES	NO	Do you currently smoke cigarettes? How many? If you smoked in the past, when did you quit?			
YES	NO	Are you currently taking medications prescribed by a doctor? If YES, indicate name of medication, dosage, and reason for taking:			

Please indicate any additional medical information you think is important for us to know prior to fitness testing or exercise. Please note any NON-prescribed medications currently taking.