Comanche Nation Fitness Center

Membership Application and Medical Information Form

Personal Information

Name: _____ Date of Birth: _____Phone Number: _____
Residential Address: _____
Gender: _____ Tribal Affiliation & Roll Number: _____

Emergency Contact Information (Must have)

Name: _____ Relationship to Client: _____Phone Number: _____
Hospital preference in case of emergency: _____

Terms and 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 and is limited to a first come first serve basis. Locks are not provided. Any locks left will be removed at the member's expense. Children under the age of 12 years will not be allowed access to the weight room or equipment. Applicants must show a Certified Degree of Indian Blood (CDIB) or valid state/government identification. Appropriate footwear (athletic shoes) must be worn at all times unless in aerobic/met area.

We reserve the right to refuse service to anyone.

By signing below, I agree to the terms and conditions.

_____ _____
Applicant Signature Date

Informed Consent Waiver

The undersigned hereby gives informed consent to engage in participating in a variety of activities. All exercises 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, weight training and callisthenic exercises performed within the 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, 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, Comanche Nation Fitness Center, Comanche Nation Fitness Center staff 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.

By signing below, I have read and understand the Informed Consent Waiver.

_____ _____
Applicant Signature Date

_____ _____
Staff Initial Date Received

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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 Disease	_____	Orthopedic or Muscular Problems

If any of the above are checked, please explain further and indicate and recommendations you 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 best describes your 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

_____ Moderately 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. _____

_____

Is there any family history (first relation) of heart disease, hypertension (high blood pressure), stroke, diabetes, heart failure, lung disease, or epilepsy? _____

Please circle appropriate 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 medication 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: _____

_____

_____ Staff Initial

_____ Date Received