Millis COA Fitness Room Application

Millis COA Fitness Room Application to Participate in the Exercise Room and Assumption of Risk

I wish to participate in activities at the Fitness Room at the Millis Council on Aging. I understand this exercise program is not under the general supervision of a health and fitness professional. The activities and equipment in the Fitness Room are generally designed to introduce and/or 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 agree to forever release and hold harmless the Town of Millis and all its employees, agents, board members, volunteers and any and all individuals and organizations assisting or participating in Fitness Room activities from any and all claims, rights of action and causes of action that may have arisen in the past, or may arise in the future, directly or indirectly, from personal injuries to myself or property damage resulting from my participation in the Fitness Room Activities. I also promise, to indemnify, defend, and hold harmless the Releasees against any and all legal claims and proceedings of any description that may have been asserted in the past, or may be asserted in the future, directly or indirectly, arising from personal injuries to myself or property damage resulting from participation in the Fitness Room activities.

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.

Name (print) _____ Date _____

Signature _____

Witness _____ Date _____

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

Revised 6/2019

Fitness Room Participants

All Fitness Room participants are required:

- **Fitness Room Application**
- **File Of Life**
- **Medical Clearance Form**
- **View an instructional video**

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Clean Shoe Policy

Fitness Room users must change into a 2nd pair of shoes prior to using the Fitness Room. A clean shoe policy is to help accomplish the paramount task of preserving the equipment in the new room. It will also save the COA and the Town a considerable amount of funds that would be needed to replace equipment prematurely, if we did not have a clean shoe policy. This type of policy is typical at most fitness centers. Thank you.

I have viewed the instructional video and provided the required documentation and agree to the terms.

Signature_____ Date_____

Millis COA Fitness Room 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?

O Arthritis / RA / joint pain	**YES / NO**	o High cholesterol / triglycerides	**YES / NO**
O Asthma / breathing problems	**YES / NO**	o Knee / hip replacement	**YES / NO**
O Circulation problems	**YES / NO**	o Liver / kidney condition	**YES / NO**
O Diabetes	**YES / NO**	o Lower back pain	**YES / NO**
O Dizziness	**YES / NO**	o Pacemaker	**YES / NO**
O Heart condition / surgery	**YES / NO**	o Pain / tightness in the chest	**YES / NO**
O Hernia	**YES / NO**	o Stroke	**YES / NO**
O High blood pressure	**YES / NO**	o 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___**
- o 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: I approve this patient for her/his participation in the Millis Council on Aging ***UNSUPERVISED*** Fitness Room.
Please, indicate any specific guidelines or limitations for this patient: _____

PHYSICIAN'S SIGNATURE: _____DATE: _____

PHYSICIAN'S PRINTED NAME: _____PHONE: _____
Please return to: Millis Council on Aging, 900 Main Street, Millis, MA 02054 Fax: 508-376-7054