

YARMOUTH COMMUNITY SERVICES
PARTICIPANT HEALTH FORM

Choose a program: **Boot Camp Fitness** **Rise n Shine Fitness** **Other:** _____

(Please print)

Participant Name: _____ Phone: _____

Emergency Contact name: _____ Relationship: _____

Emergency Phone #'s: (H) _____ (W) _____ (C) _____

2nd Emergency Contact Name: _____ Relationship: _____

2nd Emergency Phone #'s: (H) _____ (W) _____ (C) _____

Primary Care Physician: _____ Phone: _____

Insurance Company: _____ Policy #: _____

Hospital Preference: _____

Personal Health History

(Please check YES or NO)

Participant Current Health Status: _____ **YES** **NO**

- Do you often feel faint, lightheaded or have dizzy spells?
- Has your physician ever stated that you have heart problems?
- Do you frequently have pain or discomfort in your chest?
- Do you have any pain from a current or past injury or surgery?
- Are you currently being treated for high blood pressure?

If yes, please indicate current medications/treatment methods used:

- Do you have diabetes?
- Do you have asthma or any other respiratory problems?
- Has your health care provider ever stated that you have a soft tissue, bone or joint problem (i.e., arthritis) that has been aggravated or made worse by exercising?
- Are you currently participating in physical and/or occupational therapy?

If yes, where: _____

Females only: Are you currently pregnant?

If **NO**, have you given birth in the last 6 months?

Participant's Parental Health History: **YES** **NO**

- Do you have a parental history of heart attack or sudden death?
(Father - before 55 years of age; Mother - before 65 years of age)
- Do you have a parental history of diabetes?
- Are there any concerns other than those mentioned above, that we should know?

Please list: _____

I certify the above information is true and I agree to notify Yarmouth Community Services of any changes in my medical status that may or may not affect my participation in the Boot Camp Fitness program.

Note: For your personal well being, Yarmouth Community Services reserves the right to request written medical clearance for some individuals 35 years old and under.

Release: I hereby release the above information to: *Yarmouth Community Services
200 Main Street
Yarmouth, ME 04096*

Participant Signature _____ **Date** _____

A physician's clearance form (see next page) is required before participating in an YCS Fitness Program for men 45 years and older and women 55 years or older.

YARMOUTH COMMUNITY SERVICES
PHYSICIAN'S CLEARANCE FORM

**A physician's clearance form is required before participating in an
YCS Fitness Program for men 45 years and older and women 55 years or older.**

- Choose a program: **Boot Camp Fitness**
 Rise n Shine Fitness
 Other: _____

Dear Dr. _____,

Your patient _____, is interested in participating in a Yarmouth Community Services' fitness class. To ensure the health and safety of your patient we have asked that your patient fill out a **Health History form**, which indicated that your patient had a few risk factors that required **Medical Clearance** in order to participate safely in our program. Please check the appropriate box that best describes your patient's current health status.

Please return this form as soon as possible, by mail or FAX to:

Yarmouth Community Services
200 Main Street
Yarmouth, ME 04096
Phone: (207) 846-2406 Fax: (207) 846-2421

Recommendations: (Please Check One)

- Patient **MAY** participate in the above checked program class **WITHOUT** restrictions.
- Patient **MAY** participate in the above checked program class **WITH** the following restrictions:

- Patient **MAY NOT** participate in the in the *BOOT CAMP FITNESS* class at this time.
Due to this recommendation, please indicate when you feel it would appropriate for your patient to reapply. _____

Additional Comments: _____

Patient Name _____ **Patient Birth date** _____

Physician name (Please print) _____

Physician signature _____ **Date:** _____

Thank you for your time and cooperation.