BERNALILLO COUNTY PARKS AND RECREATION

COMMUNITY FITNESS CENTER(S)

Receipt # _____

Card # _____

HEALTH HISTORY QUESTIONNAIRE

(To be completed with Authorization Form, on back)

Name: _____ **Date:** _____

Please *check one*: Employee Member ____ Public Member ____

Regular physical activity *is* safe for most people. The American College of Sports Medicine Standards indicates that some individuals should check with their doctors *first* concerning their participation in an exercise program. To help us determine if *you* should consult your doctor, please read the following questions carefully and answer each one honestly.

	Please Check (√) YES or NO	*YES*	*NO*
1.	Do you have a heart condition?		
2.	Have you ever experienced a stroke?		
3.	Do you have epilepsy?		
4.	Are you pregnant?		
5.	Do you have diabetes?		
6.	Do you have emphysema?		
7.	Have you had an asthma attack within the last two years?		
8.	Are you taking asthma medications now?		
9.	Do you feel pain in your chest when you engage in physical activity?		
10.	Do you have chronic bronchitis?		
11.	In the past month, have you had chest pain when you were not doing physical activity?		
12.	Do you ever lose consciousness?		
13.	Do you ever lose control of your balance due to chronic dizziness?		
14.	Are you currently being treated for a musculoskeletal problem that restricts you from engaging in physical activity?		
15.	Has a physician ever told you or are you aware that you have high blood pressure?		
16.	Has anyone in your immediate family (parents/brothers/sisters) had a heart attack, stroke or cardiovascular disease before age 55?		
17.	Has a physician ever told you or are you aware that you have a high cholesterol level?		
18.	Do you currently smoke?		
19.	Are you a male over 44 years of age?		
20.	Are you a female over 54 years of age?		
21.	Are you currently exercising LESS THAN 1 hour per week? If you answered no, please list your activities: _____		
22.	Are you currently taking medication for blood pressure or a heart condition?		

If you answered **"YES"** to any one of questions **1-12**, or answered **"YES"** to 2 or more of questions **13-19**, we recommend that you receive medical clearance prior to your participation in an exercise program.

I have read, understood, and completed this questionnaire. Any questions that I had were answered to my full satisfaction.

Signature: _____ **Date:** _____

BERNALILLO COUNTY PARKS AND RECREATION

BERNALILLO COUNTY EMPLOYEE
FITNESS CENTER AUTHORIZATION FORM

NAME: _____ **Department:** _____

ADDRESS: _____ **Work Phone:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

All participants should obtain medical advice concerning the type of activity most suitable for them, according to the directions on the Health History Questionnaire.

MEDICAL AUTHORIZATION

CLEARED TO PARTICIPATE:

Without Restrictions ☐ **With Restrictions** ☐

Restrictions:

_____

_____

_____

_____
Signature of Physician

_____ **Date**

_____
Reviewed by Parks and Recreation

Date: _____

WAIVER OF LIABILITY

I hereby acknowledge that my participation in this fitness center is entirely voluntary on my part. Such participation is solely for my own pleasure and benefit.

In consideration of my acceptance as a participant, I, for myself, and for my successors and administrators, waive and release any and all claims and rights for damages, pain, and/or suffering I may suffer as a result of participation in this fitness center. I hereby agree to hold harmless the County of Bernalillo, its facility or staff, for any injury suffered as a result of participation in this fitness center. I attest and verify that I am physically able to take part in physical fitness activities.

I have read the above conditions and accept them, as shown by my signature:

_____ _____
EMPLOYEE NAME (Please Print) **Employee Signature**

_____ _____
Bernalillo County Representative **Date**

Reviewed by Parks and Recreation Department: _____ **Date:** _____