SWTC Fitness Center Membership

Name_____ Student____ Staff____
Address _____ Spouse of Student____ Spouse of Staff____
City/State_____ Zip_____
Phone#_____ City Member ____
Age____ Sex: M____ F____

HEALTH HISTORY (this information shall be available to Fitness Center staff only.) Have you ever or do you currently have any of the following:

O High blood pressure
O Heart disease
O Rheumatic fever
O Congenital heart disease
O Hemophilia
O Emphysema
O COPD
O Asthma
O Diabetes
O Muscle, joint, back problems
O Arthritis
O Epilepsy
O Dizziness
O Other chronic condition

Within the last 6 months:

O Surgery
O Injury requiring hospitalization
O Pregnancy

If you check off any of the above, you will need to consult your Doctor before beginning use of the Fitness Center.

_____ _____
Member Signature Date

O Referred to Family Doctor

Comments:

_____

_____

_____

_____ _____
Family Dr. Signature Date