BayCare Fitness Center

Date: ______________________________ Member Card #:___________________

Name: ____ Date of Birth: _________________ Gender: ☐ M ☐ F

Address: ____

City: ____ State: ______________ Zip: ______________

E-mail: ____ Home Phone: __________________________

Cell Phone: ____________________________

Employer: ____Work Phone:___________________________

Physician Name: ____ Phone: _______________________________

Emergency Contact: ____________________________ Relationship: _____________ Phone: ________________

How did you hear about the Fitness Center?

- ☐ Member: ____
- ☐ Physician: ____
- ☐ Employer: ____
- ☐ Other: ____

Voluntary Participation Waiver & Release

- General Medical History–I have had an opportunity to ask questions. Any questions I have asked have been answered to my complete satisfaction. I subjectively understand the risks of my participation in this activity, and knowing and appreciating the risks I voluntarily choose to participate, assuming all risks of injury or even death due to my participation.
- I understand that my signature here signifies that I have received and or been made aware of the online "Fitness Center Member Handbook". I agree to comply with the rules and regulations as they are established by St. Anthony's Health Care and Morton Plant Mease Health Care. I understand that the objective of this program is not to provide primary medical care, but is to provide a comprehensive physical improvement program.
- I, the undersigned, hereby agree to indemnify and hold harmless BayCare Health System and it's employees and staff from all claims, causes of action, damages or liabilities which may arise as a result of my participation or use of equipment in the Fitness Center. I assume responsibility for reporting any changes in my physical condition which could affect my ability to use equipment or participate in any activity class at the Fitness Center.

Signature: ____ Date: ______________________

Staff Signature: ____ Date: _________________________
(Print and Sign)

BayCare Fitness Center
BayCare Outpatient Center
900 Carillon Parkway
St. Petersburg, FL 33716
(727) 502-4444

BayCare Fitness Center
Palm Lake Shopping Center
32672 U.S. 19 N.
Palm Harbor, FL 34684
(727) 772-2254

Cheek-Powell Fitness Center
Morton Plant Hospital
455 Pinellas St.
Clearwater, FL 33756
(727) 462-7685

BayCareFitnessCenters.org

BC1506878_1015

General Medical History

Y	N	
☐	☐	1. Has your doctor ever said you have a heart condition & you should only do physical activity recommended by a doctor?
☐	☐	2. Do you feel pain in your chest when you do physical activity?
☐	☐	3. In the past month, have you had chest pain when you were not doing physical activity?
☐	☐	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
☐	☐	5. Do you have a bone or joint problem that limits or restricts your physical activity?
☐	☐	6. Are you currently taking prescribed medication for blood pressure or a heart condition?
☐	☐	7. Are you currently exercising?
☐	☐	8. Do you have any other diagnosed restrictions or limitations that are not listed above? Please explain:

____

____

Have you been diagnosed with any of the following:

Y	N	
☐	☐	Diabetes
☐	☐	Thyroid disease
☐	☐	Asthma
☐	☐	Pulmonary disease
☐	☐	Heart disease
☐	☐	Liver or Kidney disease

Please List all Medications you are taking or have recently taken:

Medication	Dose	Reason

EnvironmentalAllergies:____

Drug Allergies: ____

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