

GOTTSCHKE WELLNESS CENTER

148 E. ARAPAHOE - THERMOPOLIS, WY 82443 - 307-864-2913

WELLNESS WAIVER/LIABILITY RELEASE

NAME _____ DATE _____
ADDRESS _____
CITY _____ EMAIL: _____
HOME PHONE _____

Gottsche Rehabilitation/Wellness Center does not provide medical insurance to cover its members during their participation in the fitness center. Insurance coverage is the personal responsibility of all clients wishing to become members of this facility.

I, _____ give consent for myself and/or _____ to participate in recreational fitness/wellness programs and activities within the Gottsche Wellness Center. I hereby release the Gottsche Rehabilitation Center, all staff, and Board of Directors herewith from all liability, including claims and suits at law or in equity for any injury, fatal or otherwise while participating in any of these programs or activities.

Liability and Consent

All exercise programs/testing are designed to gradually increase workload on the cardio-respiratory and musculoskeletal systems in order to improve body function. The body's reaction to gradually increasing exercise activities cannot be predicted with complete accuracy. Unusual changes during or following an exercise session may occur. These may include muscular or joint, abnormal blood pressure, fainting, disorders of heartbeat, and/or very rare instances of heart attack or death. The Gottsche Wellness is not responsible for injuries and/or damages occurring as a result of using this facility.

Gottsche Glyphs contains advanced exercise equipment and a bouldering wall both of which could cause injury even if used correctly. Bouldering is an extreme sport where falling is common. It is up to you to know your limitations, use common sense, and maintain control at all times. The advanced flooring system will cushion falls, but cannot completely eliminate the risk of injury which is your responsibility. Safety is our top priority and if you fail to follow the rules and/or compromise the safety of others you may be asked to leave.

Unless otherwise indicated under the "comments" section below, I certify that I am in good health and have no condition that would limit/prohibit my participation in a structured exercise program. I realize injury may result from any of the any of the activities and take full responsibility for my well-being. I consent to the administration of any immediate resuscitation measure deemed advisable by my trainer or other qualified personnel.

Please initial each line if you consent with the corresponding statement.

_____ I agree to take full responsibility for any injury I may receive as a result of using the wellness center.

_____ I understand by not following the center's rules I may be asked to leave.

_____ I give permission for any photograph or video taken of myself at the center to be used in advertising, website design or other marketing purposes.

Question/Comments _____

RISK FACTOR IDENTIFICATION

Risk Factor	Points
Place an "X" on the line if applicable to your health history.	
Family History <div style="margin-left: 20px;"> <55-yr old Father or 1st degree male relative with MI or sudden death <65-yr old Mother or 1st degree female relative with MI or sudden death </div>	_____
Current Cigarette Smoking	_____
Hypertension <div style="margin-left: 20px;"> Blood pressure > 140/90 mm Hg confirmed on two separate occasions Currently taking antihypertensive medications </div>	_____
Hypercholesterolemia <div style="margin-left: 20px;"> Total serum cholesterol > 200 mg/dl Or HDL <35 mg/dl </div>	_____
Impaired Glucose Fasting <div style="margin-left: 20px;"> Fasting Glucose of > or = 110 mg/dl confirmed by measurements on two separate occasions </div>	_____
Obesity <div style="margin-left: 20px;"> BMI = weight in lbs / (height in inches)² X 703 (over 30 is classified obese) </div>	_____
Sedentary Lifestyle <div style="margin-left: 20px;"> No regular physical activities, recreational pursuits or active job </div>	_____
Total Points _____	

All clients with two or more positive risk factors should be evaluated by a physician prior to engaging in physical activity.

YES	NO	Physical Activity Readiness Questionnaire
<input type="checkbox"/>	<input type="checkbox"/>	1 Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
<input type="checkbox"/>	<input type="checkbox"/>	2 Do you feel pain in your chest when you do physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	3 In the past month, have you had any chest pain when you were not doing any physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	4 Do you lose your balance because of dizziness or do you ever lose consciousness?
<input type="checkbox"/>	<input type="checkbox"/>	5 Do you have a bone or joint problem that could be made worse by a change in physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	6 Is your doctor currently prescribing medication (for example, water pills) for your blood pressure or heart condition?
<input type="checkbox"/>	<input type="checkbox"/>	7 Do you know of any reason you should not do physical activity?

If you answered yes to two or more questions talk with your doctor by phone or in person BEFORE you start becoming more physically active.

Initial on line only:

_____ I have less than two risk factors and "YES" answers and am ready to exercise.

_____ I have two or more risk factors and/or "YES" answers and realize I should obtain a medical release prior to exercise.

HEALTH HISTORY FORM

DOB: _____ Gender: _____ Male _____ Female

Physician's Name: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

List any medications you currently take: _____

Does your physician know you are participating in this exercise program?

Yes _____ No _____

Describe any physical activity you do somewhat regularly: _____

Do you now or have you had in the past:

1. Any chronic illness or condition
2. Difficulty with physical exercise
3. Advised from physician not to exercise
4. Recent surgery (last 12 months)
5. Pregnancy (now or within last 3 months)
6. History of breathing or lung problems
7. Any previous injury still affecting you
8. Diabetes or thyroid condition
9. Hernia or condition that may be aggravated by lifting weights

YES

NO

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "YES" answers: _____

By my signature below, I acknowledge and represent that I have carefully read this document in its entirety, understand its contents and effect, and am executing it voluntarily of my own free will. I further state that I am at least eighteen (18) years of age and am fully competent to sign this agreement or am having a legal guardian sign for me as a minor.

THIS IS A RELEASE OF LEGAL RIGHTS.

READ AND BE CERTAIN YOU UNDERSTAND IT BEFORE SIGNING.

PARTICIPANT NAME (Please Print) _____ DATE _____

GUARDIAN NAME (For Minors) _____

PARTICIPANT/GUARDIAN SIGNATURE _____

IN CASE OF AN EMERGENCY PLEASE CONTACT: _____

PHONE NUMBER OF EMERGENCY CONTACT: _____

STAFF INITIALS _____