ST. JOSEPH HOSPITAL
COMMUNITY HEALTH EDUCATION

Exercise Release Form (Front and Back)

The risk of exercising is less than the risk of not exercising and I realize that there is an inherent danger in any vigorous physical conditioning program. Potential injuries can include but are not limited to: bruises, sprains and muscle pulls along with more serious problems such as heart attacks, heart rhythm abnormalities and other cardio-respiratory problems.

I also understand that I should obtain my physician's permission prior to embarking on any exercise or test program especially if I have not been engaging in strenuous or regular exercise, if I am over 40 years of age, or have a prior history of cardio-respiratory problems or prior injuries.

I certify that to my knowledge I do not have problems with heart disease, high blood pressure, pain with exertion, diabetes, convulsions, or bleeding disorders and that to my knowledge, I do not have any other chronic or acute conditions that might be aggravated by a physical fitness program or might make me more susceptible to the above mentioned risks of this exercise program. **If I have any of the above-mentioned conditions, my attending physician has to give me written permission to participate in this exercise program and such permission is attached hereto.**

I do hereby release St. Joseph Hospital of liability related to injuries or accidents, which may occur in participation in this exercise program.

_____ _____ _____

Participant Signature **Date of Birth** **Date**

_____

Please print name

Note: ***We recommend you have a check-up with your physician and obtain clearance for exercise if you:***

- **Recently had surgery**
- **Are pregnant**
- **Recently had a baby**

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Exercise Release Form (Front and Back)

I am participating in (please check one):
❑ Zumba ❑ Yoga ❑ Low Impact Aerobics ❑ Yoga for Those w/Cancer

Name: _____Date of Birth_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell or Work Phone: _____

E-mail Address: _____

Physician Name: _____ Office Phone: _____

Address: _____

Risk Factors:
Have you had or do you have *(please check all that apply)*

❑ Heart attack/Bypass surgery
❑ Angina
❑ Heart trouble of any kind
❑ Elevated cholesterol
❑ Rheumatic fever
❑ Heart murmur
❑ High blood pressure
❑ Stroke
❑ Any type of metabolic disease
❑ Alzheimer's/Dementia
❑ Arthritis
❑ Head and/or neck injury
❑ Lung disease (list type):_____
❑ Asthma
❑ Thyroid disorder
❑ Injuries to back/back problems
❑ Seizures
❑ Diabetes (list type): _____
❑ Family history of heart disease in parents or siblings prior to age of 55
❑ Any condition not listed: _____

Medications:
Check those medications that you are currently taking:

❑ Blood pressure medication
❑ Asthma medication
❑ Heart medication
❑ Other_____

Symptoms:

1. Do you have any physical condition impairment or disability, including joint or muscle problems, which limit your activities? ❑ Yes ❑ No ❑ Unknown
2. Have you ever ad angina or heavy pressure in your chest as a result of exercise, walking, or other physical activity such as climbing a flight of stairs? ❑ Yes ❑ No ❑ Unknown

_____ _____
Participant Signature **Date**