



LIFECARE REHAB – GREENBUSH – 19120 200th Street
Greenbush, MN 56726 – (218) 782-2131, FAX (218) 782-2954

LIFECARE REHAB – ROSEAU – 715 Delmore Drive
Roseau, MN 56751 – (218) 463-4787, FAX (218) 463-4788

LIFECARE REHAB– WARROAD – 201 Lake St NE PO Box 447
Warroad, MN 56763 – (218) 386-3155, FAX (218) 386-3156

AGREEMENT
Waiver, Hold Harmless and Release from Liability

I understand that there is risk of injury associated with participation in any fitness program. In consideration of participation in a fitness program, I agree to waive, release and hold harmless LifeCare Medical Center, its Board of Trustees and their agents, servants and employees from all claims, liability, demands, rights and causes of action present or future, including medical bills, fees, or expenses, whether known, anticipated or unanticipated, whether or not relating to the negligence of any officer, employee, or agent of LifeCare Medical Center, and whether or not resulting from, arising out of, or incident to my use of, presence at, or membership in this gym membership.

I HAVE READ THIS ENTIRE DOCUMENT OR HAVE HAD IT READ TO ME, AND I UNDERSTAND IT OR HAVE HAD IT ADEQUATELY EXPLAINED TO ME. BY SIGNING THIS DOCUMENT, I AGREE TO BE BOUND BY ALL TERMS AND CONDITIONS CONTAINED HEREIN ALONG WITH ALL LIFECARE POLICIES & PROCEDURES.

Printed Name: _____ Date: _____

Signed Name: _____

Parent/Guardian Name: _____ Date: _____

Health/History

Gender: Male Female D.O.B: ____/____/____ Age: _____

Height: _____ Weight: _____

Address: _____ City/State/Zip Code: _____

Phone - Home: _____ Work: _____ Cell: _____

In case of emergency, contact: _____ Phone: _____

Medical History (do you now or have you had in the past; please answer all questions)

- Yes No Heart problems: heart attack, bypass, angioplasty, stent, angina
- Yes No Heart failure
- Yes No Stroke or TIA
- Yes No Blockage in artery to: legs, neck or kidney
- Yes No Thyroid problems
- Yes No Breathing or lung problems
- Yes No Muscle, joint or back problems
- Yes No Seizure disorder
- Yes No Mental/nervous disorder
- Yes No Recent surgery or any other condition that might hinder you from exercise
- Yes No High blood pressure (140/90 or higher) or taking medicine to lower blood pressure
- Yes No High blood cholesterol (240 or higher) or taking medicine to lower cholesterol level
- Yes No Family history of early heart disease (father/mother/brother/sister before age 60)
- Yes No Diabetes (how old were you when diabetes began? _____)
- Yes No Excess Weight

Current Symptoms (please answer all questions)

- Yes No Chest pain, heaviness, tightness or burning
- Yes No Fatigue or unusual tiredness
- Yes No Unusual shortness of breath
- Yes No Pain or tightness in hips or calves with walking
- Yes No Other symptoms: _____

Any allergies (list drug/food/latex, etc.):

Your signature below authorizes staff to obtain a medical clearance from your physician if you have diagnosed heart problems, diabetes, metabolic disorders, respiratory problems or any other risk factors, before you engage in a fitness program.

Signature _____ Date _____

Fitness Program Questionnaire:

Restrictions/Modifications:

Special Considerations:

What sports do you participate in?

In your opinion what area(s) need the most improvement in your athletic abilities?

What is your personal goal entering this program?
