Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been a member of the Cardiac or Pulmonary Rehab in the Worthman Fitness Center? Yes ***\_\_\_*** No **\_\_\_\_**

May we include your name on communications/announcements that may be posted in the Fitness Center? Yes **\_\_\_\_** No **\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medical history: | YES | Taking Medication? |  | YES | Taking Medication? |
| High Blood Pressure |  |  | Seizures |  |  |
| Any heart trouble |  |  | Smoking /Tobacco use |  |  |
| Lung Disease |  |  | Chest pain/discomfort |  |  |
| Stroke |  |  | Excessive Shortness of Breath |  |  |
| High Cholesterol |  |  | Arthritis |  |  |
| Diabetes |  |  | Orthopedic Issues |  |  |

Do you have any other medical problems/concerns the staff should be aware of? Please describe below:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

It is highly recommended to have a physician’s approval to participate in exercise at the Worthman Fitness Center and the Worthman Fitness Center does reserve the right to ask for it. I do understand the risk and benefits of exercising at my own risk. I do release any and all rights and claims from damages that I have against the Worthman Fitness Center, its personnel and Worthman Fitness Center staff, for any injuries and damages which may be suffered by me in connection with my participation in the Worthman Fitness Center.

Participant Signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Parent/Guardian Signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Worthman Fitness Center Staff Signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Worthman Fitness Center*

Adams Memorial Hospital Decatur, IN

 (260) 724-2145 ext 11036

**PLEASE SEE REVERSE SIDE**

*Worthman Fitness Center*

**RULES AND REGULATIONS**

Adams Memorial Hospital Worthman Fitness Center reserves the right to question those individuals who do not comply with the following:

1. Memberships are paid monthly, if a membership is not paid for six months, the member must re-enroll. The Worthman Fitness Center DOES NOT refund unused portions of monthly membership fees.
2. Family membership: All members MUST live in the same household. “Family members” will include spouses and children. All regular dependent membership fees will be paid on the same date.
3. Each member is issued a membership card. The first card is FREE with membership. If the card needs to be replaced there is a $3 replacement fee.
4. All participants (guardian necessary for under 18) must sign a Release Agreement and provide a physician’s release if applicable. All members must be at least 14 years old. Those under 14 are not allowed to remain in the fitness center, except those participating in therapy prescribed by a physician.
5. Parent/guardian MUST accompany members under the age of 18 during the enrollment process. Participants under 18 are required to have individual instruction of appropriate equipment use. Members under 16 using the facility must be accompanied by a responsible adult.
6. AMH (Adams Memorial Hospital) Worthman Fitness Center is not responsible for lost or stolen items. Personal property should be locked in the lockers provided. Keys MUST be returned the same day.
7. Shirts and close-toed shoes must be worn while exercising in the Fitness Center.
8. Therapy and rehab patients will be given priority for the use of all equipment.
9. There is a **30-minute** time limit on use of fitness equipment when others are waiting.
10. When you finish using the equipment, please wipe off any touched surface with antibacterial wipes provided.
11. No smoking is permitted on AMH grounds. No alcoholic beverages/narcotic drugs are permitted in the Fitness Center. Those under the influence of the same will be asked to leave.
12. No food or drink is allowed in the exercise area except beverages in sealed covered bottles.
13. ALWAYS practice courtesy to other participants and staff. Profanity/obscene gestures/language WILL NOT BE TOLERATED. Personal listening devices should have headphones.
14. Report all equipment malfunctions or personal injuries sustained during exercise to the attending fitness center staff.
15. NO SOLICITING in the fitness center.
16. Photography, videos or pictures, are PROHIBITED while in the fitness center.
17. Please refrain from wearing perfume, cologne, powder or scented items to the Worthman Fitness Center in consideration of those with breathing difficulties.

I, the participant, understand these rules and regulations are intended to help construct a safe and friendly environment at the AMH Worthman Fitness Center. I agree and abide by them.

Signature of Participant: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Parent/Guardian: (if applicable)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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