City of Naples - Community Services Department

RIVER PARK FITNESS CENTER FORM

Phone: (239) 213-3037 Fax: (239) 213-3035 Email: riverpark@naplesgov.com

RELEASE OF LIABIITY WAIVER

River Park Informed Consent for Exercise Participation and Fitness Assessment

I desire to engage voluntarily in an exercise program at The River Park Fitness Center to improve my physical fitness. I may voluntarily engage in exercise assessments to evaluate my physical fitness.

I understand there is a risk of abnormal cardio-respiratory response during and following exercise, I understand that I am responsible for monitoring my own condition throughout exercise, and agree to stop exercise and inform a member of the center's staff should any unusual symptoms occur. I understand that I can discontinue my exercise program or fitness assessment at any time.

Medical clearance is recommended before beginning any exercise program. If medical clearance is specifically requested prior to beginning an exercise program or fitness assessment, I will consult my physician and obtain said clearance prior to beginning my exercise program.

I have read this form and understand the nature of the exercise program and fitness assessment. My questions have been answered to my satisfaction. I agree to assume the risk of such exercise and assessment, and agree to hold harmless The City of Naples and/or The River Park Fitness Center , their staff members.

FITNESS CENTER RULES & REGULATIONS

- Profanity, vulgarity or suggestive music in the fitness room is prohibited and will result in a suspended membership.
- Music is kept to a volume that is sustainable and not overwhelming. Also, personal music may be used as long as they do not cause any hazard or nuisance to other users.
- Each television is dedicated to sports, news, and family friendly or local channels.
- The use of cell phones inside the fitness center is prohibited.
- Only Fitness Center member will be allowed entry.
- Each patron must be checked by the front desk.
- The door is NOT to be opened for anyone !
- Proper workout attire is required.
- Horseplay, profanity, racist, or sexist comments will not be tolerated in this facility. Any individual displaying these types of behaviors will be asked to leave immediately and may be subject to suspension.
- Good order, proper attire, decorum and consideration of the rights and comforts of others must be observed at all times.
- Disorderly conduct and horseplay will not be tolerated.
- Profane, loud and/or abusive language will not be permitted.
- Any Fitness Member who conducts themselves in an unbecoming manner, or who knowingly violates any of the Membership Rules may be denied service and or access to the Fitness Center or may have their Membership suspended or forfeited.
- The Fitness Center will accept Check, Cash, Visa or MasterCard as payment for dues. All dues or fees associated with membership shall be paid in advance of use of facility. Checks shall be made payable to "City of Naples".
- Any complaints regarding the conduct of River Park fitness members should be reported directly to River Park Staff.
- Use the disinfectant and towels to wipe equipment clean before moving to another station.
- Do not drop weights, dumbbells or bars.
- Members are to return dumbbells, weight plates, bars and other equipment to their correct locations in the weight room.

Signature of Participant **Signature of Parent if Under 18** **Date**

(Note: If submitting this form electronically, please type your name and date on the corresponding lines above. Also, please review the Electronic Submittal disclaimer on the following page.)

MEDICAL HISTORY QUESTIONNAIRE

LAST NAME: _____ **FIRST:** _____ **M.I.** _____

MEMBER #: _____ **DOB:** _____ **AGE:** _____ **GENDER:** ☐ **Male** ☐ **Female**

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Fax:** _____

Email Address: _____

I. PARTICIPATING SCREENING

Check all true statements

History

I have had:

- ☐ a Heart Attack
- ☐ Heart Surgery
- ☐ Cardiac Catheterization
- ☐ Coronary Angioplasty (PTCA)
- ☐ Pacemaker/Implantable Cardiac Defibrillator /Abnormal Heart rhythms
- ☐ Heart Transplantation
- ☐ Congenital Heart Disease
- ☐ Stroke
- ☐ Peripheral Vascular Disease

Cardiovascular Risk Factor

- ☐ I am a man older than 45 years
- ☐ I am a woman older than 55 years
- ☐ I have had a complete hysterectomy or am postmenopausal
- ☐ I smoke.
- ☐ My blood pressure is greater than 140/90.
- ☐ I don't know my blood pressure.
- ☐ I take blood pressure medicine.
- ☐ My blood cholesterol level is greater than 240mg/dl.
- ☐ I don't know my cholesterol level.
- ☐ I have a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister).
- ☐ I am diabetic or take medicine to control my blood sugar.
- ☐ I am physically inactive (i.e. I get less than 30 mins of physical activity on at least 3 days per week.)
- ☐ I am more than 20 pounds overweight.

If you marked two or more of the statements in this section, we may require that you consult your healthcare provider before engaging in exercise.

I have answered the above questions truthfully to the best of my knowledge.

_____ _____

Signature of Partcipant **Date**

(Note: If submitting this form electronically, please type your name and date on the corresponding lines above.)

Symptoms

- ☐ I experience chest discomfort with exertion.
- ☐ I experience unreasonable breathlessness.
- ☐ I experience dizziness, fainting, blackouts.
- ☐ I take heart medications.

Other Health Issues

- ☐ I have musculoskeletal problems.
- ☐ I have concerns about the safety of exercise.
- ☐ I am Pregnant.

If you marked any of the statements in this section, we require that you consult your healthcare provider before engaging in exercise.

Additional Health History

1. Are you presently on medications? ☐ Yes ☐ No
   If so, please list and for what reasons:

   Are you allergic to any medications? ☐ Yes ☐ No
   If so, please list:

2. Do you have any conditions or past injuries which limit the range of motion of your muscles, joints, bones spinal column, or any other part of your body which may be aggravated by exercise? ☐ Yes ☐ No
   If so, please explain:

3. Check if you had any of the following:
   - ☐ Asthma
   - ☐ Chronic Bronchitis
   - ☐ Arthritis
   - ☐ Fibromyalgia
   - ☐ Emphysema
   - ☐ Kidney Disease
   - ☐ Liver Disease
   - ☐ Epilepsy
   - ☐ Cancer

4. Current Weight: _____ Height: _____
   Target Weight: _____

5. Would you be interested in having:
   - ☐ a Personal Trainer
   - ☐ an Aerobic Class
   - ☐ Fitness Assessment
   - ☐ Self-defense Class

ELECTRONIC SUBMITTAL

(NOTE: The button used to submit this form (via email) will appear upon checking the box and agreeing to the terms below. Saving this entire form for electronic submittal requires a minimum of free Adobe Reader version 11 (or greater), or Adobe Acrobat Standard / Pro).

☐ **By checking this box, typing your name in the applicant/citizen signature field(s), and submitting this form electronically (via email), you affirm that all information contained within this document was completed truthfully, and to the best of your knowledge and you understand that your electronic signature is considered legally binding the same as signing your physical signature by hand.**