Desert Hot Springs Health & Wellness Center
Cardio-Fitness Center Application

Last Name, First Name	Today's Date:	Home Phone:	Cell Phone:
Mailing Address:	**City**	**Zip Code**	**Work Phone:**
Email	**Date of Birth**	**Gender**	**Email**
		Please Circle M / F	
Emergency Contact Name	**Relationship**	**Emergency Phone 1**	**Emergency Phone 2**

Medical Questionnaire

Please indicate if you are currently under treatment or have experienced any of the following:

- ☐ Hypertension/High Blood Pressure
- ☐ Diabetes
- ☐ Physical injury _____
- ☐ On medication that may cause drowsiness
- ☐ Seizures, dizziness or fainting
- ☐ Heart Disease
- ☐ Currently Pregnant
- ☐ Asthma or Respiratory disease
- ☐ Other_____

Please read the questions carefully and answer each one honestly: check YES or NO.

YES ☐ NO ☐ 1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?

YES ☐ NO ☐ 2. Do you feel pain in your chest when you do physical activity?

YES ☐ NO ☐ 3. In the past month, have you had chest pain when you were not doing physical activity?

YES ☐ NO ☐ 4. Do you lose your balance because of dizziness or do you ever lose consciousness?

YES ☐ NO ☐ 5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?

YES ☐ NO ☐ 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?

YES ☐ NO ☐ 7. Do you know of any other reason why you should not do physical activity?

Anyone who has a history of chronic illness that may affect their ability to safely use the equipment may need to provide medical clearance prior to gym use. If you have answered "Yes" to one or more of the above questions, you are required to consult with your physician before engaging in physical activity here at the DHS Health & Wellness Center. Tell your physician which questions you answered "Yes" to and after a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition. You may need to restrict your activities to those which are safe for you. Talk with a your doctor about the kinds of activities you wish to participate in and follow his/her advice. Please ask our staff for a Medical Clearance Form that will need to be completed by your physician.

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Waiver of Liability

I hereby understand and acknowledge that the cardio-fitness center, training, programs, and events held at the Desert Hot Springs Health and Wellness Center may expose me to many inherent risks, including accidents, injury, illness, or even death. I understand that I am expected to exercise at my own risk. All exercises, including the use of weights and use of any and all machinery, equipment and apparatus designed for exercise shall be at the member's sole risk. Member understands that the agreement to use, or selection of exercise programs, methods and types of equipment shall be members' entire responsibility and Borrego Health, The City of Desert Hot Springs, nor The Health Care District shall be held responsible to members for any claims, demands, injuries, damage or actions arising due to injury to members' person or property arising out of or in connection with the use by member of the services, facilities and premises of the Desert Hot Springs Health and Wellness Center. Member hereby holds all entities harmless, its officers, owners, agents and employees harmless from all claims which may be brought against them by member or on member's behalf for any such injuries or claims.

I understand that this Waiver of Liability and Membership policy is valid for one year from enrollment date. The membership fee is non-refundable and non-transferable even if the member chooses to discontinue utilizing the premises. Membership must be renewed on or before the date of anniversary in order to continue accessing the gym. Payment is due at the time of establishing membership and may be collected in cash, debit or credit card. No checks are accepted.

By my signature I indicate that I have read and understand this Waiver of Liability. I am aware that this is a waiver and a release of liability and I voluntarily agree to its terms.

Member's Signature	Staff Member's Signature
Date:	Date:
Printed Name:	Printed Name:

To be Completed by Staff Only

Staff Member's Name:_____

Physician Medical Clearance Obtained?

▫ Yes ▫ No ▫ N/A

▫ Referral to DHS main campus for medical clearance

▫ Obtaining clearance from personal doctor/hold membership

▫ Date of clearance _____/_____/_____

▫ Adaptive Equipment Needed

NOTES:

Membership Details:
Member Fees:
▫ Paid:$_____ ▫ Not Paid

Method of Payment:
▫ Cash
▫ Debit Card
▫ Credit Card
▫ Visa ▫ Master Card
▫ AMEX ▫ Discover
NO Personal Checks Please

Membership Effective Date: _____/_____/_____

Fitness Center Orientation Date: _____/_____/_____