YORK GENERAL
Wellness Center

York General Wellness Center Hours

Mon - Thurs 5:00 am - 9:00 pm
Friday 5:00 am - 6:00 pm
Saturday 7:00 am - 4:00 pm
Sunday 12:00 pm - 4:00 pm

NAME _____ TAG NUMBER _____

DATE OF BIRTH _____ AGE _____ GENDER _____

ADDRESS _____

PREFERED CONTACT METHOD ☐TEXT ☐EMAIL PHONE _____

EMAIL _____

EMERGENCY CONTACT NAME _____

RELATIONSHIP _____ PHONE _____

COMPANY _____ JOB ACTIVITY LEVEL ☐SEDENTARY ☐ACTIVE

POSITION _____ WORK PHONE _____

What about your MEDICAL HISTORY will help us better serve your health needs? (example: diabetes, joint replacement, high blood pressure, heart issues, etc.) _____

_____

_____

List of Medications : _____

_____

Physician's Clearance

MEDICAL CLEARANCE GUIDELINES

Because of the acute risks involved in participation in exercise classes, medical guidelines have been established by Kenneth Cooper, MD, from the Aerobic Center in Dallas, Texas. Dr. Cooper suggests:

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Under 30: You can start exercising if you have had a checkup within the past year and the doctor found nothing wrong with you.

30 to 39: You should have a checkup within three months before you start exercising. The examination should include an electrocardiogram (EKG) taken at rest.

40 to 59: Same as for the 30-39 age group with one important addition. Your doctor should also take an EKG to check your heart while you are exercising. Your pulse rate during the test should approach the level it would during aerobic workouts.

Over 59: Same as the 40-59 age group except that the examination should be performed immediately before embarking in any exercise program.

DR. _____ PRACTICE _____

PHONE _____ DATE OF LAST EXAM _____

*Please sign **PART A or PART B***

PART A

Physician's Clearance

After reading the foregoing guidelines, I would like my physician to know I have started an exercise program.

_____ _____ _____

Participant Signature | Date | Physician's Signature

PART B

Physician's Waiver

I understand the need for program entry guidelines and medical clearance. Even though my present health status may suggest a physician's clearance, I wish to participate in an exercise program at my own risk. I agree to indemnify and hold harmless the instructor of the Wellness Center, facility, York General Hospital Wellness Program. In case of injury to myself, I hereby waive all claims against the organizers and/or instructors.

_____ _____

Participant Signature | Date

Our Focus is You.

Waiver

I understand that if I have any of the following conditions, I must receive my physician's approval before participating in an exercise program:

1. Respiratory Disease
2. Uncontrolled High Blood Pressure
3. Insulin-Dependent Diabetes
4. Morbid Obesity
5. Signs or Symptoms of Heart Disease
6. Pregnancy
7. Seizure Disorder

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I understand my participation in any exercise classes or programs through the Wellness Center is in no way a substitute for the medical care rendered by my personal physician. I am aware that the practice of exercise is not an exact science and I acknowledge that no guarantees have been made concerning the benefits or risks involved to me participating in such activity.
I agree to assume any and all risk involved in or arising for my use of the facility including, risk of death, bodily injury, the unavailability of emergency medical care, or the negligence or deliberate acts of another person. I further agree to hold York General Hospital, Inc., its officers, directors, employees, and agents completely harmless from any and all claims, causes of action, injuries, damages, costs or expenses arising out of my use of or presence upon York general Hospital Inc.'s property and facilities. I further agree to indemnify it from any and all claims, causes of action, damages, judgments, costs or expenses, including attorney fees, which in any way arise from my use or presence upon property and use of said facilities.
I am aware of the risks and possible discomforts that my participation in the program may bring on, such as:

1. Adverse body signs and symptoms
2. Muscle-joint soreness and/or injuries
3. Potential life-threatening cardio respiratory problems

I agree to make every effort to utilize the facility and equipment properly and make every effort to apply the exercise principles that I'm taught. I understand that should my health status change or should my prescribed medications change, I must assume responsibility for questioning my health provider as to my ability to continue exercise.
I understand that a physician is not present during any component of this program. If physical injury should occur as a consequence of my participation in this program:

1. Basic first aid and CPR will be available to me
2. Expenses for medical care beyond immediate on-site first aid will not be assumed by the hospital or any of the staff

I am aware that I may elect not to participate, or that I may withdraw participation at any time.
I understand that if my blood pressure should exceed 160/100, I will not be allowed to exercise without a doctor's written permission.
All information obtained as a result of my utilization of the facility for participation in any programs would be treated as privileged and confidential. This information may be used for billing, statistical, or scientific purposes with my right of privacy mentioned.
This agreement shall be binding upon personal representatives, my successors, assigns and me.

I, the undersigned, understand the above policy and am aware that I am financially responsible for such fees.

Participant Signature _____ Date _____

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