

Zest For Life Exercise Participation Agreement

I have voluntarily chosen to participate in fitness activities involving physical exercise offered by Zest For Life, Western Michigan University. I have truthfully and completely answered the medical questions and affirm that my physical condition is good and I have no conditions that prevent me from participating in fitness activities. Furthermore, I agree to monitor my physical condition and terminate any activity immediately if it exceeds my personal limitations or if I experience any unusual symptoms while exercising. I understand that Zest For Life recommends improving physical fitness through an exercise plan consisting of a gradual warm-up, aerobic exercise, strength development, and a cool-down. I also realize that participation is at my own pace and I am free to discontinue my participation at any time.

I understand that by signing this agreement, I hereby waive and release Western Michigan University, its president, Board of Trustees, staff and employees and any and all persons or organizations involved in any way from any and all claims, liabilities or demands of any kind as a result of any injury, loss or adverse health condition arising from my participation in fitness programs. I realize that I am not required to participate in physical activity, but do so voluntarily.

I affirm that I have read and fully understand the above document and I wish to participate in fitness activities.

Signature of Participant

Date

Cholesterol _____
Triglycerides _____
HDL _____
LDL _____
Ratio _____
Blood Pressure _____

Medical Release Agreement

I hereby authorize the release of my cholesterol and blood pressure results to the Zest For Life office.

Signature of Participant

Date

Zest For Life
2000 Student Recreation Center
Western Michigan University
Kalamazoo, MI 49008
Phone: (269) 387-3543
Fax: (269) 387-3766

Medical Clearance

Dear Dr. _____

I, _____, desire to participate in Western Michigan University's Employee Wellness Program. Zest For Life fitness classes are designed to improve physical fitness by safely and effectively improving flexibility, muscular strength and cardiovascular endurance. A sub-maximal fitness testing option is also available.

I was required to complete a Health History Questionnaire before participating in the exercise programs. My questionnaire indicates that I have an increased risk in the following area(s):

____ Family history of heart disease	____ Weight
____ Personal history of heart disease	____ Smoking
____ Abnormal EKG history	____ Blood Pressure
____ Age	____ Stressful behavior characteristics
____ Triglycerides	____ Sedentary lifestyle
____ Diabetes	____ Cholesterol
____ Other _____	

I am requesting your written clearance prior to exercise participation and/or fitness testing. It is understood that this opinion constitutes no legal accountability. I realize the clearance is based on the necessary evaluation by my physician to ensure that I am in good enough health to participate in an exercise program. However, the choice to exercise ultimately rests with me and I accept full responsibility.

I hereby authorize the release of my cholesterol and blood pressure results to the Zest For Life office.

Signature of Participant

Date

Physician: Please advise by choosing one of the following guidelines:

____ I need to further evaluate my patient before giving a medical clearance. Upon completion of the evaluation, I will provide you with guidelines for establishing an exercise program.

____ Based on my knowledge of the patient's health status, there are no medical contradictions to prevent him/her from participating in a supervised exercise program and/or fitness testing.

Comments/Limitations: _____

Please include your patient's cholesterol and blood pressure evaluation results if available.

Cholesterol _____ Triglycerides _____ HDL _____ LDL _____ BP _____

Signature of Physician

Date

Please return to:

Zest For Life
2000 Student Recreation Center
Western Michigan University
Kalamazoo, MI 49008
Phone: (269) 387-3543

Health Information

This form is intended to obtain relevant information about your health that will assist the staff in helping you with your program. Please answer all questions to the best of your knowledge.

Date _____

Name _____ SS# _____

Address _____

Phone _____ DOB _____ Email Address (if available) _____

Please Check: _____ Clerical/Technical _____ AFSCME
 _____ Administrative/Professional _____ Faculty
 _____ Emeriti/Retiree _____ Spouse

Current Physician _____ Phone _____

In Case of Emergency notify _____ Phone _____

Medications you are currently taking (include non-prescription) _____

Personal Health History:

Blood Pressure _____ Cholesterol _____
 How active is your current lifestyle? _____ Little or no activity _____ Somewhat active
 _____ Moderately active _____ Very active

1. Has a doctor ever told you that you have a heart condition and recommended only medically supervised activity?	Y	N
2. Do you smoke?	Y	N
3. Do you have chest pain brought on by physical activity?	Y	N
4. Have you developed chest pain in the past month?	Y	N
5. Have you on one or more occasions lost consciousness or fallen over as a result of dizziness?	Y	N
6. Do you have a bone or joint problem that could be aggravated by the proposed physical activity?	Y	N
7. Has a doctor ever recommended medication for your blood pressure or heart condition?	Y	N
8. Are you aware, through your own experience or a doctor's advice, of any other physical reason that would prohibit your from exercising without medical supervision?	Y	N

If you answered yes to any of the above questions, then a physician's consent is required before exercising or performing an exercise test. Other factors requiring a physician's consent are as follows:

- Blood pressure \geq 160/100 or on blood pressure medication
- Cholesterol \geq 240 mg/dl
- Any history of heart problems (abnormal EKG, heart surgery, symptoms of cardiovascular disease)

