

Barcode ID: _____



Vanderbilt **Orthopaedic Institute**
Fitness Center

Standard Member Application

	Sequence	Required/Optional	Date	Staff Initials
1	Signed Agreement	Required	____/____/____	
2	Signed Waiver	Required	____/____/____	
3	Fees Collected/ID Card Produced	Required	____/____/____	
4	Completed Par-Q	Required	____/____/____	
5	Health Hx Questionnaire	Required	____/____/____	
6	Physician Clearance	PRN	____/____/____	
7	Orientation - Facility Tour	Required	____/____/____	
8	Equipment Orientation #1	Required	____/____/____	
9	SF-36 Document Issued	Required	____/____/____	

To be completed by Fitness Center Staff ↑

New Member Information – to be completed by member ↓

Name: _____	Date: ____/____/____
Address Line 1: _____	
Address Line 2: _____	
City: _____	State: _____ Zip Code: _____ - _____
Date of Birth: ____/____/____	Age: _____ Sex: Female Male
Home Telephone: (____) _____ - _____	Work Telephone: (____) _____ - _____
Cellular Telephone: (____) _____ - _____	Emergency Telephone: (____) _____ - _____
Emergency Contact Name: _____	
e-mail address: _____@_____	Who Referred you: _____



PAR – Q

Physical Activity Readiness Questionnaire

Regular physical activity is an excellent way at reducing the risk of cardiovascular disease and is a key component in leading a healthy lifestyle; it should be fun as well as healthy. However for some individuals it is important to check with your doctor before beginning a regular exercise program.

If you are between the ages of 15 – 70 this PAR – Q form will give us information on whether you should consult with your physician prior to exercising. If you are over 70 years of age and not very active please check with your doctor.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
<input type="checkbox"/>	<input type="checkbox"/>	2. Do you feel pain in your chest when you do physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	3. In the past month have you had chest pain when you were doing physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you lose your balance due to dizziness or do you ever lose consciousness?
<input type="checkbox"/>	<input type="checkbox"/>	5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	6. Is your doctor currently prescribing drugs (for example: water pills) for your blood pressure or heart condition?
<input type="checkbox"/>	<input type="checkbox"/>	7. Do you know of <u>any other reason</u> why you should not do physical activity?

If you answered YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start physical activity or BEFORE you have a fitness appraisal. Tell your doctor about the PAR – Q and which question you answered YES to.

- You may be able to do any physical activity you want as long as you start slowly and build up gradually. Or you may need to restrict your activities to those which are safe for you. Talk with your doctor about activities you would like to do and follow his/her advice.

If you answered NO to all questions

If you answered NO to all the questions you can be reasonably sure that you can:

- Start becoming more physically active – begin slowly and build up gradually.
- Take part in a fitness appraisal – this is an excellent way to determine your basic level of fitness so you can plan the best way to live actively.

Please Note: If your health changes so that you answer YES to any of the above questions, notify your health professional

I have read, understood and completed this questionnaire. Any questions I had were answered to my satisfaction.

Name: _____

Date: _____

Signature: _____

Witness: _____

Note: If the PAR – Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal and administrative purposes.



VANDERBILT ORTHOPAEDIC INSTITUTE FITNESS CENTER
HEALTH HISTORY QUESTIONNAIRE

NAME: _____ DATE: _____

PHYSICIAN'S (PCP) NAME: _____

PHYSICIAN'S (PCP) PHONE: _____

Are you currently taking any prescription medications? YES/NO

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Does your physician know you are participating in an exercise program? YES/NO

Please List any physical activities that you currently perform regularly.

1.

2.

3.

4.

Do you now, or have you in the past had:

	YES	NO
History of heart problems, chest pain or stroke		
Increased blood pressure		
Any chronic illness or condition		
Difficulty with physical exercise		
Advice from physician not to exercise		
Recent surgery (last 12 months)		
Pregnancy (now or in the last three months)		
History of breathing or lung problems		
Muscle, joint or back disorder, or any previous injury Still affecting you		
Diabetes or thyroid condition		
A cigarette smoking habit		
An obesity issue (more than 20 percent over your ideal body weight)		
Increased blood cholesterol		
History of heart problems within your immediate family		
Hernia, or any condition that may be aggravated by lifting weights		

Please Explain any “YES” Answers in the Space Provided Below.

I have reviewed the above written material and attest that it is true, any and all questions regarding this information have been answered to my satisfaction.

Signature

Date

Vanderbilt Orthopaedic Institute Fitness Center Agreement and Express Release of Liability and Waiver of Any Claims by the Undersigned

In consideration of gaining membership or being allowed to participate in the activities and programs of Vanderbilt Orthopaedic Institute Fitness Center /Vanderbilt University Medical Center and access to use of it's facilities, equipment, and machinery in addition to payment of any fee or charge, I do hereby waive expressly release and forever discharge Vanderbilt Orthopaedic Fitness/Vanderbilt University Medical Center and it's officers, agents, employees, and representatives and all others from any and all responsibilities or liability for injuries resulting from my participation in any activities or my use of equipment or machinery in above-mentioned facilities or arising out of my participation in any activities at said facility. I do also hereby expressly release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of the Vanderbilt Orthopaedic Institute Fitness Center /Vanderbilt University Medical Center or use of any equipment at the Vanderbilt Orthopaedic Institute Fitness Center /Vanderbilt University Medical Center. I hereby certify, by my initials below, that I have read the foregoing statement and fully understand the consequences of my express release of liability waiver of claims.

Initial here: _____

I understand and am aware that strength, flexibility, and aerobic exercise, including the use of fitness equipment, is a potentially hazardous activity. I also understand that fitness activities involve a risk of injury even death and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death. I hereby certify, by my initials below, that I have read the foregoing statement and fully understand the consequences of this assumption of risk and do so voluntarily by my choice.

Initial here: _____

I further declare myself to be physically sound and suffering from no conditions, impairment, disease, infirmity, or illness that would prevent my participation in any of the activities at the Vanderbilt Orthopaedic Institute Fitness Center /Vanderbilt University Medical Center or use of equipment or machinery. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise and training equipment so that I might have recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given my physician's permission to participate, or that I have decided to participate in activity and/or use of equipment and machinery without the approval of my physician and do hereby expressly assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

Initial here: _____

Member Signature: _____ Date: ____/____/____

Staff Member Signature: _____ Date: ____/____/____

Membership Application and Agreement to pay

Individual Monthly Membership

\$50.00 initiation fee

\$50.00 per month.

I, _____, agree to pay \$ 50.00 per month for membership to the Vanderbilt Orthopaedic Institute Fitness Center. I understand that my fees are due in advance of participation no later than the 5th work day of each month of membership. I agree that I am accountable for payment of \$50.00 per month until I officially terminate my membership. I understand that in order to officially terminate my membership, I must provide a written notice to the Fitness Center Front Desk a minimum of 30 days prior to the effective date of termination.

Item	Fee	Total
Non-Refundable Initiation Fee	\$50.00	\$
Monthly Fee	\$50.00	\$
1 st Month Pro-Rate	\$25.00	\$
<i>Total Collected</i>		\$

Method of Payment

_____ Initials. All monthly Payments are collected through credit card automatic draft by no later than the 5th of each month. I agree to have my membership dues paid monthly by my (Visa/Mastercard/American Express/Discover) card. I understand I will **not** receive a monthly bill. All payments are non-transferable, non-refundable and any unpaid balance will be paid upon termination of my membership. Any unpaid balance may be subject to action by a collection or credit agency.

or

_____ Initials. I agree to allow the VOI Fitness Center to deduct my monthly membership fees, pro-shop fees, or other fees assessed to my account from my bi-weekly/monthly paycheck per the Vanderbilt Orthopaedic Institute Fitness Center Payroll Agreement. (Please fill out Deduction Agreement Form.)

I understand that physician clearance **is** **is not** required for me to begin participation. If required, I agree to provide physician clearance document prior to beginning use of facility.

By my signature below, I attest that I have read, understand and agree to the terms of the membership that appear above, including but not limited to the fees, method of payment, and termination of membership. I understand and recognize that the initial fees must be collected during the orientation appointment by a Vanderbilt Orthopaedic Institute Fitness Center Staff Member. Further, I attest that all of the above is correct to the best of my knowledge.

New Member Signature

Date

Staff Witness Signature

Date

Physician's Statement and Clearance Form

At the Vanderbilt Orthopaedic Institute Fitness Center, your safety is our primary concern. For that reason, we comply with the health and fitness standards of the American College of Sports Medicine and the International Health, Racquet and Sportsclub Association.

On the Health History Questionnaire you just completed, you identified that you have one or more coronary and/or other medical risk factors which may impair your ability to exercise safely. For this reason, you need to have a physician complete and return this medical clearance form before you can begin exercising at the Vanderbilt Orthopaedic Institute Fitness Center.

We recognize that you are eager to start your fitness program, and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your exercise experience at the Vanderbilt Orthopaedic Institute Fitness Center to be as safe as possible.

In order to expedite this process, we will gladly fax this form directly to the physician of your choice. If the doctor is aware of your medical history, he/she may be able to complete this form and fax it right back to us. In many cases the delay is only one day.

I hereby give my physician permission to release any pertinent medical information from any medical records to the staff at the Vanderbilt Orthopaedic Institute Fitness Center. All information will be kept confidential.

Printed Name: _____ Signature: _____

Information requested for: Vanderbilt Orthopaedic Institute Fitness Center at Vanderbilt Medical Center

Reason for Medical Clearance: _____

Physician's Name: _____ Phone: _____ Fax: _____

Address: _____

For Physician Use Only

Please check one of the following statements:

- I concur with my patient's participation with no restrictions
- I concur with my patient's participation in an exercise program if he/she restricts activities to:

- I do not concur with my patient's participation in an exercise program (if checked, the individual will not be allowed to join the Vanderbilt Orthopaedic Institute Fitness Center)

Reason: _____

Physician's name (type or print) _____

Physician's signature: _____ Date: ____/____/____

Please return fax to: Membership, Vanderbilt Orthopaedic Institute Fitness Center

Phone: (615) 322-4540

Fax: (615) 322-3984