



Name: _____ Phone: _____ Age: _____ Sex: M F
(Please Circle one)

Address: _____

City: _____ State: _____ Zip: _____

SESSION TIME:

_____ 7:00 - 8:15 a.m. (9-12 Grades) _____ 8:15 - 9:30 a.m. (6-8 Grades)

T-Shirt Size (Adult sizes ONLY): S M L XL XXL (Please Circle one)

Registration Fee: \$115*(fee includes weight room)*Family cap \$250

*****PAYMENT IS DUE PRIOR TO PARTICIPATION UNLESS OTHER PAYMENT ARRANGEMENTS HAVE BEEN MADE.*****

MAIL OR DROP OFF PAYMENT TO:
Windom Area Health
c/o Wellness Center
2150 Hospital Drive
Windom, MN 56101

Signature of participant, parent or guardian (If under 18 years of age.)

_____ Date: __/__/__

(Signature)

HEALTH QUESTIONNAIRE:

1. Birth Date: __/__/__ Height: _____ Weight: _____

3. Clinic: _____ Phone #: _____ - _____ - _____

4. Doctor: _____

5. Have you ever been diagnosed with any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Heart Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Other, please explain: _____ | | |

6. Do you have any of the following?

Back Pain Joint, tendon, or muscular pain Lung disease (asthma, emphysema, other)

Please explain: _____

11. Have you experienced chest pain due to physical activity? Yes No

12. Have you experienced chest pain within the last month? Yes No

13. Have you lost consciousness or fallen due to dizziness? Yes No

14. Are you under a doctor's supervision for any illness or physical condition that may affect your ability to exercise? Yes No Condition: _____

15. Are you pregnant? Yes No

16. Please list any medications you take on a regular basis: _____

I hereby consent to having my child/active adult participate in the Windom Area Health POWER AND ACCELERATION program. I understand that there are risks involved in such participation and relinquish Windom Area Health and Windom Area Schools from all liability. If my child/active adult has a pre-existing injury or medical condition, a written clearance from our physician is required before my child/active adult can participate. I also give my permission for the free use of my child's name and/or pictures for publicity.

Parent's or Guardian's Signature (if under 18): _____

Home Phone #: _____ - _____ - _____ Work Phone #: _____ - _____ - _____

QUESTIONS? Call Windom Area Health Wellness Center at 507-831-0672.