



Registration

Last Name

First Name

Date of Birth

_____ M M / D D / Y Y

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone # _____ **Secondary Phone #** _____

□ Mobile

Emergency Contact Name: _____ **Phone #** _____

E-mail Address: _____

By providing your e-mail address, you are authorizing us to notify you of class cancellations and other important information.

How did you hear about us? _____

By providing your e-mail address, you are authorizing us to notify you of class cancellations and monthly calendar updates.

How did you hear about us? _____

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Medical History

Has a doctor ever said you have heart trouble or a heart condition?	<input type="radio"/> NO <input type="radio"/> YES _____
Do you frequently suffer from pains in your chest?	<input type="radio"/> NO <input type="radio"/> YES
Do you have high blood pressure?	<input type="radio"/> NO <input type="radio"/> YES
Do you have high cholesterol?	<input type="radio"/> NO <input type="radio"/> YES
Do you often feel faint or have spells of severe dizziness?	<input type="radio"/> NO <input type="radio"/> YES
Do you have a bone or joint problem that can be made worse by exercise?	<input type="radio"/> NO <input type="radio"/> YES _____
Do you have Diabetes — insulin controlled or uncontrolled?	<input type="radio"/> NO <input type="radio"/> YES
Are you taking any medications such as Beta-Blockers, diet pills, or herbal supplements?	<input type="radio"/> NO <input type="radio"/> YES
Are you pregnant?	<input type="radio"/> NO <input type="radio"/> YES
Do you have any allergies? (ie. Medication, insects, food)	<input type="radio"/> NO <input type="radio"/> YES _____

IMPORTANT: If you answered "yes" to two or more of the above questions, you may be at risk of potential complications during a rigorous exercise program. A release from your physician to participate in this program is *highly* recommended. By signing below you agree you have answered this health history form truthfully and understand it is in your best interest to obtain a physician's release if you are at increased risk.

Signature: _____ Date: _____

LIABILITY WAIVER & RELEASE — I declare that I wish to participate in fitness activities at Studio Fit, a division of Health Solution Consultants, LLC. I have been advised by the staff of the importance and/or need of a physical exam and of the risk of injury in an exercise program. I hereby represent and warrant that I am physically capable of participating in the program and I am not aware of any physical illness or condition that could increase my risk of injury during such participation. I understand there are risks of injury associated with participation. I am aware of the risks inherent in any exercise/health program, including, but not limited to, severe personal injury and death. I understand that through my participation, I accept the risks of possible injury. I, on behalf of my heirs, personal representative agents or assigns, hereby waive and release Studio Fit, Stephanie Verdecchia, and all employees, volunteers, and staff from any and all claims, costs, liabilities, expenses or judgments, arising out of my participation in the Studio Fit Group Exercise programs and use of the facilities for such activities. I also agree to indemnify and hold harmless Stephanie Verdecchia and those affiliated with such from and against any such claims. I have read and understand the above Waiver and Release. I understand that there are risks of injury involved in participating in aerobic exercise, and I voluntarily assume such risks. I attest that I am physically fit to participate in the group fitness-training program.

Signature: _____ Date: _____