Confidential *Confidential*

Addendum A
Health Unlimited Family Fitness & Aquatic Center
103 Century Drive, Mt. Airy, MD 21771
301-829-9730/410-795-0793

Member Profile Sheet

Name: _____ Preferred Name/Nickname: _____

Address: _____

City: _____ Zip: _____ County: _____

Home Phone #: _____ Daytime Phone #: _____

E-Mail Address: _____

Sex: M___ F___ Date of Birth_____

Spouse's name _____ # of children _____

In Case of Emergency Contact:_____ Phone:_____

Type of Membership: Single___ Couple___ Parent/Child___ Family___ Student___

A profile sheet is required for every member on the family membership.

Have you worked out in other health clubs? Yes____ No____
Name of Club: _____Dates of membership: _____

How did you find out about Health Unlimited? _____

I declare the above information to be truthful and that I am the person who I am representing myself to be, as outlined in the information above.

_____ _____ _____
Member Name (Print) Member signature Date
(Parent or Guardian if under 18)

Waiver of Liability

I, as signed below, acknowledge, for myself or the minor child indicated below, if applicable, that I have inspected the premises at Health Unlimited and am aware that there are risks and dangers involved in using exercise equipment and engaging in exercise activities. I recognize that unanticipated and unexpected dangers may arise from engaging in such activities and that exercise can be strenuous and subject to risk of serious injury, including death. As such, I agree, for myself and/or any minor child indicated below, that engagement in physical exercise at Health Unlimited, participation in any program or activity with Health Unlimited, and use of any club amenity, on or off the premises, including any club sponsored event, is done willingly and entirely at my or my child's own risk and do hereby release Health Unlimited, its employees, officers, heirs and assigns, from any and all liability for physical or mental injury uncured to my person or that of my child, due to ordinary negligence or other fault associated with the use of the facilities, participation in programs or activities with Health Unlimited, and/or instruction offered by Health Unlimited.

Furthermore, Health Unlimited does not seek to collect and maintain personal health information on their members and, as such, I acknowledge that I have been provided with a Health Status and Physical Fitness Assessment form (attached) that I am to utilize, perhaps in conjunction with a medical professional, to determine for myself whether or not I should obtain clearance from my physician, for myself or my minor child, prior to beginning a program of unsupervised exercise at Health Unlimited.

_____
Print Name

_____ _____
Signature **Date**
(Parent or Guardian if under 18)

_____
Print Name of Parent/Guardian

Health Status and Physical Fitness Assessment

This form is intended to provide *you*, the participant, with information that will allow *you* to make a decision regarding your ability to engage in a program of regular exercise. **The staff of Health Unlimited is not medically trained to make such a decision and, as such, recognizes that *should one or more of the following conditions apply to your health history or present lifestyle, you may want to consider obtaining your physician's approval for medical clearance to engage in an unsupervised exercise program.***

		Yes	No
1.	Are you a smoker?	____	____
2.	Do you have a history of heart disease or stroke?	____	____
3.	Do you have any family history of heart/artery disease or stroke?	____	____
4.	Does a member of your immediate family have a history of heart/artery disease before the age of 50 years?	____	____
5.	Do you have a history of High Blood Pressure, have a blood pressure of 140/90 or greater at rest, or are you taking any blood pressure medication?	____	____
6.	Do you have any chronic conditions requiring medical supervision or treatment (i.e. diabetes, epilepsy, rheumatoid arthritis, etc.)	____	____
7.	Are you on medication that may restrict your activity in any way?	____	____
8.	Are you over 35 years of age and sedentary? (No regular exercise in the last 6 months).	____	____
9.	Do you experience any symptoms such as chest discomfort, spells of dizziness, or periodically feel faint?	____	____
10.	Do you have a cholesterol level of above 240 mg/dl?	____	____
11.	Are you Obese? (Based on the NIH Conference on Obesity) Men: over 25% body fat or 20% overweight Women: over 35% body fat or 20% overweight	____	____
12.	Have you had any recent illness, hospitalization or surgical procedure?	____	____

The purpose of this form is to make you aware of any existing health problems which may impact your risks associated with exercise. If you checked "YES" to any of the above questions, or have any other medical concerns or otherwise are unsure of your ability to tolerate an exercise regimen, you may want to consult your physician before beginning an exercise program.