

# Lewis & Clark Orthopedic & Sports Therapy

## Lewis & Clark Athletic Circuit Training Program

2525 Fox Run Pkwy, Suite 100, Yankton, SD 57078 • PHONE 605-260-0918 • FAX 605-260-0912

### Registration, Health History, and Consent

Date: \_\_\_\_\_

Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone#: \_\_\_\_\_ Height (ft/in): \_\_\_\_\_ Weight (lbs): \_\_\_\_\_

(list # we can text class info)

Mailing Address: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Parent Phone #: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Physician Phone #: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_ Current School Name: \_\_\_\_\_

Sports: \_\_\_\_\_

Allergies: \_\_\_\_\_

List current medications (prescription and non-prescription): \_\_\_\_\_

#### Past Medical History:

(if yes, please explain)

Prior difficulty with exercise?	Yes _____	No _____
Ever ordered not to exercise or lift by physician?	Yes _____	No _____
High blood pressure?	Yes _____	No _____
Heart Problems, Arrhythmias, Murmur?	Yes _____	No _____
Family History of Heart Problems?	Yes _____	No _____
Chest pain or stroke?	Yes _____	No _____
Difficulty with breathing, asthma, lung problems?	Yes _____	No _____
Surgery in last year?	Yes _____	No _____
Currently pregnant or was in last 3 months?	Yes _____	No _____
Diabetes or Thyroid Disorder?	Yes _____	No _____
Obesity?	Yes _____	No _____
Prior injury to back/neck, joint, or muscle affecting exercise?	Yes _____	No _____
Hernia?	Yes _____	No _____
Other chronic illness or condition?	Yes _____	No _____

Date of last physical exam by physician: \_\_\_\_\_

Any other information we should know/concerns: \_\_\_\_\_

ACKNOWLEDGE THAT I HAVE THOROUGHLY READ THIS FORM IN ITS ENTIRETY AND UNDERSTAND IT. I UNDERSTAND THAT BY SIGNING THIS FORM I AM RELEASING LEWIS AND CLARK ORTHOPEDIC AND SPORTS THERAPY ITS AGENTS AND EMPLOYEES FROM ANY AND ALL LIABILITY FROM MY PARTICIPATION IN THE LEWIS AND CLARK ATHLETIC CIRCUIT TRAINING PROGRAM. I UNDERSTAND THAT I AM WAIVING AND GIVING UP SUBSTANTIAL RIGHTS BY SIGNING AND STATE THAT I AM SIGNING FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT, PROMISE OR GUARANTEE. I INTEND MY SIGNATURE TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY AND WAIVE MY RIGHT TO MAKE ANY CLAIM AGAINST LEWIS AND CLARK ORTHOPEDIC AND SPORTS THERAPY.

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

(required if under 18 years old)

Classes will be 8am-10am Monday, Tuesday, and Thursday starting June 12<sup>th</sup> and ending July 24<sup>th</sup>.

Cost is \$110 payable to Lewis & Clark Specialty Hospital – mail payment with form to address above. Please contact us for other payment options.

Participants must be at least 14 years old.

Any other information will be mailed to you as necessary. Thank you!!