

Membership Application and Agreement

Primary Member Information *(Completed by Applicant)*

Name: _____

Address: _____

E-Mail: _____

Do you wish to receive our FREE Monthly e-newsletter, packed with tons of training info? Yes / No

Phone # (Home): _____ (Work): _____ (Cell) _____

Birthday: ____ month ____ day ____ year (optional) Gender: ____ male ____ female (optional)

Waiver and Release

(Signed by Applicant and Parent/Guardian if under 18 years of age)

I agree to abide by the rules of Finish First Sports Performance, including completion of a pre-activity screening questionnaire and/or health/medical information questionnaire prior to participation in any physical activities at the Finish First Sports Performance (FFSP) facilities. I further agree that all use of the FFSP facilities, programs and services shall be undertaken at my sole risk and that FFSP shall not be liable for any injuries, accidents, or death occurring to me, including those resulting from FFSP's negligence arising either directly or indirectly out of my participation in FFSP's facilities, programs, and services, including those resulting from FFSP's negligence. I for myself and on behalf of my executors, administrators, heirs, and assigns, do hereby expressly release, discharge, waive, relinquish, and covenant not to sue FFSP, its affiliates, officers, directors, agents or employees for all such claims, demands, injuries, damages or causes of action, including those resulting from FFSP's negligence, arising either directly or indirectly out of my participation in, or use of, FFSP's facilities, programs and services.

I declare that I have completed FFSP's pre-activity screening questionnaire and/or health/medical information questionnaire and that I am physically able to participate in physical activity. Furthermore, I acknowledge that FFSP has advised me to obtain a physician's clearance in the event the answers on either the pre-activity screening questionnaire and/or health/medical information questionnaire indicates that I should not participate in a program of physical activity without a physician's clearance, or if FFSP is unsure of my physical health, yet I maintain that I am physically capable of pursuing physical activity in the FFSP facility.

Member's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

FFSP Staff Signature: _____ Date: _____

Health History (Information) Questionnaire

Please complete this form in its entirety and give it to a Finish First Sports Performance Coach.

Name: _____ Gender: _____ Birthdate: _____
Address: _____
Phone (H): _____ (W): _____ (C): _____
E-Mail: _____ Fax: _____

Regular physical activity is enjoyable and healthy, and for most people, safe. However, some individuals may have health risks that might require them to check with their physician prior to starting an exercise/performance training program. To help determine if there is a need for you to see your physician before starting an exercise/performance training program, carefully read and answer the following questions. All information will be kept strictly confidential.

I. PHYSICAL ACTIVITY SCREENING QUESTIONS (Please answer yes or no to each of the following)

- | | | |
|-----|----|---|
| Yes | No | 1. Has your physician ever told you that you have a heart condition? |
| Yes | No | 2. Do you experience chest pain when you are physically active? |
| Yes | No | 3. In the past month, have you experienced chest pain when not performing physical activity? |
| Yes | No | 4. Do you lose balance because of dizziness or do you ever lose consciousness? |
| Yes | No | 5. Do you have a bone or joint problem that could be aggravated by a change in your level of physical activity? |
| Yes | No | 6. Is your physician currently prescribing medication for your blood pressure or heart condition? |
| Yes | No | 7. Do you know of any other reason why you should not participate in a program of physical activity? |

If you answered yes to any of the questions above, it is recommended that you consult with your physician, by phone or in person, before having a fitness/performance evaluation and/or participating in a physical activity/performance training program.

II. GENERAL HEALTH HISTORY QUESTIONS (Please answer yes or not to each of the following)

- | | | |
|-----|----|---|
| Yes | No | 1. Have you ever had a stroke? |
| Yes | No | 2. Do you have diabetes? If yes, are you currently taking any medications or receiving other treatment related to diabetes? Yes No |
| Yes | No | 3. Do you have asthma or another respiratory condition that causes difficulty with breathing?
If yes, please describe: _____ |
| Yes | No | 4. Do you have any orthopedic conditions that would restrict you in performing physical activity?
If yes, please describe: _____ |
| Yes | No | 5. Have you ever been told by a physician that you have one of the following?
(Circle all that apply)
High Blood Pressure
Elevated blood lipids, including elevated cholesterol
Cardiovascular disease
Cancer
Other health/medical condition (please describe): _____ |
| Yes | No | 6. Do you currently smoke or have you smoked in the past and stopped within the past six months? |
| Yes | No | 7. Do you currently have back pain or have you had back pain within the past six months or felt discomfort that prevented you from carrying out normal daily activities? |
| Yes | No | 8. Are you currently taking any medications for a health or medical condition? If yes, please indicate which medications you are taking. _____ |
| Yes | No | 9. Are you pregnant? |

If you answered yes to any of the questions above, it is recommended that you consult with your physician, by phone, or in person, before having a fitness/performance evaluation and/or participating in a prescribed physical activity program. In some instances, depending upon the answers you provided to the questions above, you may be required to obtain a physician's written clearance before an exercise/performance training program can be designed for you.

Member Information Form *(Completed by the Member)*

Member Name: _____

Member Phone #: _____ Email: _____

Emergency Contact: _____

Emergency Phone #: _____

Sport(s): _____

Date of Birth: _____

Occupation: _____

Member's Availability (Days per week you are committed to physical training): _____

Previous Injuries (List all, including known dates): _____

Known Exercise Restrictions/Limitations: _____

In terms of physical fitness, what do you think is your greatest weakness? _____

Your greatest strength? _____

In your own words, define success (what it means to you)? _____

What are you willing to give up, to sacrifice to achieve success (your goals)? _____

Name 2 Short-term physical fitness goals, and 2 long term physical fitness goals: _____
