

St. John the Baptist Fitness Program



Health Screening Tool and Medical Release Form

Name _____ Age _____ DOB _____

Address _____ Phone # _____

_____ Cell Phone # _____

Emergency Contact:

Name _____ Relationship _____

Address _____ Phone # _____

Other Contact _____ Relationship _____

Address _____ Phone # _____

Mark any of the following that you have been or are currently treated for by your MD:

- | | |
|------------------------------|---|
| _____ High Blood Pressure | _____ Heart Disease/Heart Attack |
| _____ Diabetes | _____ Stroke |
| _____ Arthritis/Osteoporosis | _____ Alzheimer's Disease/Parkinson's Disease |
| _____ High Cholesterol | _____ HIV/AIDS |
| _____ Depression | _____ Kidney/Prostate Problems |
| _____ Cancer | _____ Breathing Problems/Emphysema/Chronic Bronchitis |
| _____ Sleeping Problems | _____ Headaches |
| _____ Other _____ | |

Immunizations and medical care:

Allergies _____

Medications/Oxygen _____

To be completed by your Primary Physician

WITH RESTRICTIONS

Physician's Name _____ Phone _____

I have examined _____ and feel he/she is able to participate in an exercise program with the following restrictions: _____

MD Signature _____ **Date** _____

OR

NO RESTRICTIONS

Physician's Name _____ Phone _____

I have examined _____ and feel he/she is able to participate in an exercise program with NO restrictions.

MD Signature _____ **Date** _____