TEXTRON AVIATION EMPLOYEES CLUB
517-2800
Participant Information

Thank you for your interest in The Textron Aviation Employees Club Fitness Center. Because your health and safety are our priorities, we are asking that you provide us with the following information.

Please complete this form and return it to the front desk.
Thank you.

Please Print
Name: _____
Last First M.I.

Member
- ☐ Employee/Retiree
- ☐ Spouse
- ☐ Dependent
- ☐ **Guest**
- ☐ **Personnel**

Participant Information:

Male ☐ Female ☐ Birthday: ____ / ____ / ____ Badge No. _____

Phone: (H)_____ (W) _____

Street Address_____

City _____State_____ Zip Code_____

Emergency Contact _____Phone _____

Your personal physician _____

SCREENING QUESTIONS

If you score 11 points or more you will be required to have your physician complete the "Physician Authorization" before you may participate.

1. Do you have any of the following risk factors for heart disease or stroke: *(check all that apply)* **3 pts. each; N/A 0 pts.**
   ☐ Diabetes ☐ High blood pressure ☐ Smoking
   ☐ Obesity *(More than 20 lbs. overweight)* ☐ High cholesterol ☐ N/A
   ☐ Family history of heart disease or stroke

2. Have you ever had any of the following signs or symptoms of heart disease or circulatory disease? *(Check all that apply)* **3 pts. each; N/A 0 pts.**
   ☐ an abnormal EKG ☐ N/A
   ☐ rapid or irregular heart beat
   ☐ pain or pressure in chest during or immediately following exercise, walking, or physical or sexual activity
   ☐ as a result of walking several blocks experience severe pain in your calf (lower leg), which then subsides with rest

3. Have you ever had any of the following signs or symptoms of lung disease? *(Check all that apply)* **7 pts. each; N/A 0 pts.**
   ☐ asthma, bronchitis, emphysema, or any other lung condition ☐ N/A
   ☐ severe shortness of breath with activity

4. Do you take any heart or blood pressure medications such as: Quinidine, Nitroglycerin, Lopressor or Diazide? **7 pts**
   ☐ Yes ☐ No

5. Have you ever experienced any of the following? *(Check all that apply)* **11 pts. each; N/A 0 pts.**
   ☐ Coronary artery disease ☐ N/A
   ☐ Heart Attack
   ☐ Angina (chest pain or pressure)
   ☐ Heart valve problems
   ☐ Coronary heart disease

6. Are you pregnant?
   ☐ Yes (If "yes" **add 11 pts.**) ☐ No ☐ N/A **0 pts.**

7. If you are over the age of forty, has it been more than six months since you participated in active exercise? Active is considered to be regular aerobic (cardiovascular) exercise, at least three times a week for a minimum of twenty/thirty minutes duration. Examples: jogging, swimming, cycling, brisk walking or hard physical labor.
   ☐ Yes ☐ No ☐ N/A

8. Do you have any musculoskeletal problems, such as: arthritis, rheumatism, gout or injuries; please list:
   Surgical history: _____
   Please list any medications: _____

9. Are you aware of any reason, not mentioned above for limiting your participation in exercise/ recreation activities and/or participation in a fitness evaluation?
   ☐ Yes ☐ No
   If yes, please explain:_____
   _____

Office Use Only
Staff_____ Date_____

TOTAL POINTS
_____
If You Have 11 Points Or More Please See The Physician's Authorization On Back.

INFORMED CONSENT

You should be aware of the possible risks you might encounter by participating in fitness and recreation activities and/or participating in a fitness evaluation. The programs will be centered around activities that include running/jogging/walking, stretching, muscle toning, and exercises using fitness equipment.

The most acute risk would be death caused from cardiac failure during exercise. Other medical problems that could result from your participation, but are not limited to: sore muscles, cramping, torn or pulled muscles, sprains, fractures, cartilage or ligament damage to major joints, nausea during and after exercise, loss of weight, and possible loss of appetite.

You may also incur some environmental risks if exercising outside, such as dog bites and traffic/pedestrian accidents. If you participate in water exercise, death from drowning would also be a risk.

Your participation is voluntary and you may withdraw at any time. Please give your consent with full knowledge of the nature and types of exercise you will be doing and the discomforts/risks which may be encountered. Thank you for helping us be medically prudent.

I acknowledge that all information on this form is true to the best of my knowledge and I will inform the Center Management of any change in my health status. I hereby agree to abide by the established rules and regulations of the center with the understanding that my noncompliance may result in the termination of my privileges.

Signature _____ **Date**_____

If under 18, name, address, and signature of parent or guardian is required.

Name: _____ Address:_____

Signature _____ Date_____

PHYSICIAN AUTHORIZATION TO PARTICIPATE

If you scored 11 points or more, based on your answers to the Screening Questions, you are required to get written authorization from your physician before you may utilize the Textron Aviation Employees Club Fitness Center.

NOTE TO PHYSICIAN:

We are delighted that your patient is becoming a member of the Textron Aviation Employees Club Fitness Center. The Center's programs and activities are self-directed. When requested, we do give general advice and instructions on exercise, equipment, and use of the facility. Please fill out the following information regarding your patient. If you have any questions or concern, please feel free to call us at 517-2800.

Are there any limitations to exercise? ☐ Yes ☐ No

If yes, please give diagnosis:_____

Limitations: _____

Special Instructions: _____

With the understanding that the Textron Aviation Employees Club Fitness Center is NOT a medically supervised program, I have examined this applicant and approve his/her participation in the Textron Aviation Employees Fitness Center. Any exer-cise limitations/precaution should be listed above.

Physician's Signature_____ Date_____

Physician's Telephone:_____