

Total Health

GUEST AGREEMENT WAIVER WITH BRIEF HISTORY

Date _____

Name _____

DOB _____

Guest of _____

Primary Care Dr _____

Mailing address _____

City _____

State _____

Zip _____

Phone (Home) _____

(Work) _____

Please answer the following questions:

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has your doctor ever said you have heart trouble? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you frequently have pains in your heart and chest? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you often feel faint or have spells of severe dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Has a doctor ever said your blood pressure was too high? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Has your doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise or might be made worse by exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Is there any good physical reason not mentioned here why you should not follow an activity program even if you wanted to? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Are you over age 65 and not accustomed to vigorous exercise? |

Guest Agreement/Waiver

The undersigned guest agrees to abide by the rules of Total Health, including the completion of the above medical questionnaire.

The undersigned guest agrees that all use of Total Health's facilities, services and programs shall be undertaken at his/her sole risk and Total Health shall not be liable for any injuries, accidents or deaths occurring to guest, arising either directly or indirectly out of utilizing Total Health's facilities, services and programs. The guest, for him/herself and on behalf of his/her executors, administrators, heirs and assigns, does hereby expressly release, discharge, waive, relinquish, and covenants not to sue Total Health, its officers and agents for all such claims, demands, injuries, damages or cause of action, with respect to use of Total Health's facilities, programs and services.

The undersigned guest declares that he/she has completed the enclosed medical questionnaire as required by Total Health and that he/she declares he/she is physically able to participate in physical activity. Furthermore, guest declares that Total Health has advised guest to obtain a medical clearance in the event he/she answer yes to any of the medical history questions, or if he/she is unsure of his/her physical health and that guest maintains that he/she is physically capable of pursuing physical activity in Total Health without such steps being taken or has done so.

Guests Signature _____ Witness _____

Parent/Guardian _____ Date _____