

FAIR LAWN SENIOR CENTER HEALTH QUESTIONNAIRE

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Birth Date: _____ Sex: _____ M _____ F

EMERGENCY CONTACT:

Name: _____ Relation: _____ Phone #: _____

Do you have, or have you had a history, or experience with the following: (Please Circle)

High Blood Pressure	Yes	No	Low Blood Pressure	Yes	No
High Cholesterol	Yes	No	Diabetes	Yes	No
Chest Pains	Yes	No	Joint Problems	Yes	No
Heart Attack	Yes	No	Heart Disease	Yes	No
Severe Headaches	Yes	No	Asthma	Yes	No
Dizziness	Yes	No	Musculoskeletal Disorders	Yes	No
Recent Surgeries	Yes	No	Epilepsy	Yes	No
Arthritis	Yes	No	Phlebitis	Yes	No
Emphysema	Yes	No	Thyroid Problem	Yes	No
Peripheral Vascular Disease	Yes	No	Chronic Bronchitis	Yes	No
Cancer	Yes	No	Embolism	Yes	No
Aneurysm	Yes	No	Shortness of Breath	Yes	No
Osteoporosis	Yes	No	Stroke	Yes	No
Coronary By-Pass	Yes	No	Pacemaker	Yes	No
Heart Murmur	Yes	No	Allergies	Yes	No

Do you have any chronic injuries or physical limitations? If so, please describe: _____

Are you taking any medications? If so, please list: _____

I acknowledge that the information provided to be true and accurate. To the best of my knowledge, I have given all relevant information regarding my health and ability to participate safely in an exercise program. In case of injury I do hereby waive all claims of liability, personal injury and medical expense payments against the Borough of Fair Lawn, its servants, agents or employees and/or subdivision thereof.

Signature: _____ Date: _____

Reviewed by: Donna J. Neill _____ *Nancy Whittaker* _____ *Date* _____

PHYSICIANS CLEARANCE

We recognize that you are eager to continue your participation in our Fitness Program, and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your exercise experience with the Fair Lawn Senior Center to be as safe as possible. For this reason, we have implemented the policy of requiring a physician's clearance. In order to expedite this process, we will gladly fax this form directly to the physicians of your choice.

FOR PARTICIPANT USE ONLY

I hereby request Dr. _____ to complete this form in order to allow my participation in the Fitness Program at the Fair Lawn Senior Center.

Participant's Name (printed): _____

Participant's Signature: _____ Date: _____

FOR PHYSICIAN USE ONLY

The above mentioned participant of the Fair Lawn Senior Center is hereby cleared to return to his/her Fitness Class: Please check one of the following statements:

_____ I concur with my patient's participation with no restrictions.

_____ I do not concur with my patient's participation in an exercise program

Physician's Name (printed): _____

Physician's Signature: _____ Date: _____

Please return completed form to:

Fair Lawn Senior Center
11-05 Gardiner Road
Fair Lawn, NJ 07410

or

Fax: 201-475-0524

FOR SENIOR CENTER USE ONLY

Received By: _____ Date: _____