MWSU

RECREATION SERVICES

Baker Family Fitness Center
Guest Agreement and Release of Liability Form

Name: _____ Sex: M F Date of Birth: ___/___/___ Age: _____

Guest of: _____ Member's G#: _____

Member is a(n): MWSU Student MWSU Faculty/Staff MWSU Dependent

NOTE: The Self-Administered Health History Form must be filled out and paired with this Agreement and Release of Liability to be complete. If the Health History form warrants concern for physical activity, a medical clearance must be obtained from a physician PRIOR to exercise.

In consideration of being allowed to use the facilities and equipment at the MWSU Baker Family Fitness Center, I do hereby waive, release, and forever discharge MWSU and all of its employees and representatives from any and all responsibilities or liability for injuries or damages resulting from my participation or my use of equipment at the aforementioned facility. I do hereby release all of those mentioned and any others acting on their behalf from any responsibility or liability for any injury or damage to myself, including those caused by negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my use of this facility.

Please initial here: _____

I understand and am aware that strength, flexibility, and aerobic exercise, including use of the equipment, is potentially hazardous activity. I also understand that the fitness activities involve risk of injury and even death and that I am voluntarily participating in these activities and using equipment and machinery with the knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

Please initial here: _____

I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation in the use of any of the equipment in this facility. I do hereby acknowledge that I have been informed of the need of a physician's approval for my participation in exercise or in the use of exercise equipment and machinery. I acknowledge that I must have a physician's clearance prior to exercise if I am at one of the ages specified above. I acknowledge that I assume all responsibility for my participation, activities and utilization of equipment and machinery if I do not fall under the age requirements for a physician's clearance.

Please initial here: _____

Completing this Agreement and Release of Liability entitles the guest access to the Baker Family Fitness Center *with their Member* for the academic year that the form is completed.

_____ _____

Signed Date

_____ _____

If under 18, signature of parent or guardian Date

MWSU RECREATION SERVICES

Self-Administered Health History Form

Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. Please answer the following questions to help you determine if you should consult a doctor before starting exercise. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

YES	NO	
☐	☐	1. Do you have a heart condition?
☐	☐	2. If you are male, are you 45 or over? If you are female, are you 55 or over?
☐	☐	3. Has your doctor ever told you only to do physical activity recommended by a doctor or do you have other reason to believe that you should not do physical activity?
☐	☐	4. Do you feel pain in your chest when you do physical activity?
☐	☐	5. In the past month, have you had pains in your chest when you were not doing physical activity?
☐	☐	6. Do you lose your balance because of dizziness or do you ever lose consciousness?
☐	☐	7. Do you CURRENTLY have a bone or joint problem that is either- Made worse by physical activity? Or is under restrictions by a physician?
☐	☐	8. Are you on medication for high blood pressure or heart condition?

YES TO ONE OR MORE OF THE ABOVE INDICATES NEED FOR MEDICAL CLEARANCE PRIOR TO EXERCISE

☐	☐	9. Has anyone in your immediate family (parents, brothers, sisters) had a heart attack, stroke, or cardiovascular disease before age 55?
☐	☐	10. Are you aware that you have a high cholesterol level?
☐	☐	11. Do you currently smoke?
☐	☐	12. Are you currently exercising less than one hour per week? If no, please list your activities: _____

YES TO TWO OR MORE OF THE ABOVE INDICATES NEED FOR MEDICAL CLEARANCE PRIOR TO EXERCISE

In case of emergency, contact: _____ Phone: _____

PLEASE CONTINUE ON OTHER SIDE

INFORMED CONSENT

I declare that I intend to use all or some of the activities, facilities, programs, and services offered by the Missouri Western State University Baker Family Fitness Center. I also understand that each person, including myself, has a different capacity for participating in such activities, facilities, programs, and services. I am aware that all activities, services, and programs offered are either educational, recreational, or self-directed in nature. I assume full responsibility, during and after my participation for my choice to use or apply, at my own risk, any portion of the information or instruction I receive.

I understand that part of the risk involved in undertaking any activity or program is relative to my own state of fitness or health and to the awareness, care, and skill with which I conduct myself in the activity or program. I acknowledge that my choice to participate in any activity, service, and program of this fitness center brings with it any assumption of those risks and results in stemming from this choice of fitness, health, awareness, care, and skill that I possess and use.

I further understand that some of the services, programs, and activities offered by the fitness center are sometimes conducted by individuals that may not be licensed, certified, or registered instructors or professionals. I accept the fact that the skills and competencies of some employees and/or volunteers will vary according to their training and experience and that no claim is made to offer assessment or treatment of any mental or physical disease or condition by those who are not duly licensed, certified, or registered.

I recognize that by participating in the activities, facilities, programs, and services offered by the fitness center, I may experience potential health risks such as transient light-headedness, fainting, abnormal blood pressure, chest discomfort, leg cramps, and nausea and that I will assume willfully those risks. I acknowledge my obligation to immediately inform the nearest supervising employee of any pain, discomfort, fatigue, or any other symptoms that I may suffer during and immediately after my participation. I also understand that I may be requested to stop any activity if the supervising employee is not comfortable with my participation in the activity.

I understand that I may ask any questions or request further explanation or information about activities, facilities, programs, and services offered by the fitness center at any time- before, during, or after my participation.

I have been informed of the fitness center rules and guidelines and I agree to adhere to them. I understand that I may be asked not to return if I fail to abide by the stated rules and guidelines.

I declare that I have read, understood, and agree to the contents of this health history questionnaire and this informed consent in their entirety.

Signed	Date
If under 18, signature of parent or guardian	Date
Baker Family Fitness Center Staff Witness	Date

☐ Form was noted into Banner _____ BFFC Staff Initials