SENTARA
RMH Wellness Center

Pre-Activity Screening Form

Please print clearly.

(Circle one)Mr./Mrs./ Ms Name:_____ Age: _____ Date of Birth: _____

Home Address:_____City: _____State/Zip:_____

Telephone:_____E-mail Address: _____

Emergency Contact Name: _____Emergency Contact Phone: _____

Regular physical activity is enjoyable, safe, and healthy for most people. However, some individuals may have health-related risks that might be aggravated by participation in a physical-activity program, and, as a result, might require them to check with their physician prior to beginning a physical-activity program. To help determine if there is a need for you to see your physician before beginning an exercise program, please answer the following questions carefully. All information will be kept strictly confidential.

I am aware of the possibility of minor, serious, fatal, accidental or other injury or illness occurring during or as a result of exercise or activity programs on Sentara RMH Wellness Center's property. I understand that in the event of a medical emergency, the SRMH Wellness Center will utilize 9-911 services and notify the emergency contact person listed above.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Yes	**No**	
□	□	1. Has your physician ever told you that you have a heart condition?
□	□	2. Do you experience chest pain when you are physically active?
□	□	3. In the past month, have you experienced chest pain when not performing physical activity?
□	□	4. Do you lose balance because of dizziness or do you ever lose consciousness?
□	□	5. Do you have a bone or joint problem that could be aggravated by a change in your level of physical activity?
□	□	6. Is your physician currently prescribing medication for your blood pressure or a heart condition?
□	□	7. Do you know of any other reason why you should not participate in a physical-activity program?

If you answered yes to any of the questions above, it is recommended that you consult with your physician, by phone or in person, before having a fitness test or participating in a physical-activity program. If you wish to forgo this recommendation, please sign, and see Option B on the backside.

I have read and understand the above information: Signature:_____Date:_____

For Office Use Only: □ Information entered into CSI □ Information entered into mailing list

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Please choose Option A or B

☐ **Option A: Physician's Clearance**

Answering yes to one or more of the previous questions has identified you as being high risk. It is advised that you consult with you physician and provide documentation of such consult prior to participating in physical activity at this facility.

Authorization for the Exchange of Medical Information with my Physician:

I, _____, hereby authorize the exchange of any relevant medical or health related information between the SRMH Wellness Center and Dr. _____. I understand this consent can be revoked at any time except to the extent that disclosure made in good faith had already occurred in reliance of this consent.

Patient's Signature: _____
Date: _____

Patient Name: _____
Date of Birth: _____
Physician: Dr._____
Physician's Phone Number: (540)_____
Physician's Fax Number: (540)_____

PHYSICIAN: Please check the box that reflects your opinion for the above patient and sign:

_____ A. I concur with my patient's participation in physical activity at the Wellness Center.
Recommendations for exercise assessment and program:
_____
_____

_____ B. I do not concur with my patient's participation in physical activity at the Wellness Center.
Reason:
_____

_____ C. I will determine the patient's ability to participate in physical activity at the Wellness Center based upon a physical exam and/or consultation.*

_____ _____
Physician's Signature Date

**A Wellness Center staff member will contact your patient to inform them of your wishes.*

☐ **Option B: Assumption of Risk**

I understand that I have declined a pre-activity screening or that I wish to participate prior to physicians consent and have been informed of the basic risks involved in participating and have chosen not to follow the guidance provided by the center's staff. I assume responsibility for my own actions and release RMH Wellness Center from any legal responsibility from claims or suits arising from my participation at the center or in the center's programs. By refusing to sign this waiver I understand that I am precluded from participating in the program activities of this facility.

Member Signature: _____ Date: _____