



Patron Information Form

Spouse/Partner
 Educator Prep
 Dependent
 Retiree
 Aramark Employee
 Follett Employee

Name:		Date:
Street Address:		City:
State:	Zip Code:	Email:
Phone #:		Age:
Emergency Contact:		Phone #:
SC Sponsor's Name:		Relationship to Sponsor:

Application Instructions:

1. For complete information regarding patron eligibility, policies, and benefits, visit www.spfldcol.edu/campusrecreation.
2. Each patron (including Dependents) must complete both sides of this Patron Information form. The back side includes a health history questionnaire to help determine your readiness for participation in physical activity.
3. The completed form should be brought into the Campus Recreation office for approval. (Proof of dependency or cohabitation may be required.)
4. The Campus Recreation office will stamp this form approved and provide the patron with a copy. The patrons copy should be brought to the Business Office to pay \$10.00 for the ID and then they will be issued a receipt. They should take the receipt to the Springfield College ID office between the hours of 9:00 a.m. – 4:30 p.m. to obtain his/her Springfield College identification card. This office is located in the Information Technology Services department on the ground floor of Babson Library in room B23B. (Dependents under 18 years of age will not be issued an ID card.)
5. The Springfield College ID card is required for access into the Wellness and Recreation Complex. (Dependents under 18 years of age must be accompanied with their parent/guardian at all times.)

Agreement and Waiver:

The undersigned visitor agrees that all use of the Springfield College Wellness and Recreation Complex shall be undertaken at his/her sole risk and the Springfield College shall not be liable for any injuries, accidents or deaths occurring to the visitor, arising either directly or indirectly out of utilizing the Wellness Center and Recreation Complex. The visitor, for him/her and on behalf of his/her executors, administrators, heirs and assigns, does hereby expressly release, discharge, waive, relinquish, and covenants not to sue Springfield College, its officers and agents for all such claims, demands, injuries, damages or cause of action, with respect to use of the Wellness and Campus Recreation Complex. The undersigned visitor declares that he/she is physically capable of pursuing physical activity in the Wellness and Campus Recreation Complex. The undersigned visitor agrees to abide by the rules of the Springfield College Wellness and Recreation Complex.

Signature is required on other side



AHA/ACSM Health/Fitness Facility Preparticipation Screening Questionnaire

Assess your health status by marking all the **true** statements:

<p>History You have had: <input type="checkbox"/> a heart attack <input type="checkbox"/> heart surgery <input type="checkbox"/> cardiac catheterization <input type="checkbox"/> coronary angioplasty (PTCA) <input type="checkbox"/> pacemaker/implantable cardiac defibrillator/rhythm disturbance <input type="checkbox"/> heart valve disease <input type="checkbox"/> heart failure <input type="checkbox"/> heart transplantation <input type="checkbox"/> congenital heart disease</p> <p>Symptoms <input type="checkbox"/> You experience chest discomfort with exertion <input type="checkbox"/> You experience unreasonable breathlessness <input type="checkbox"/> You experience dizziness, fainting, or blackouts <input type="checkbox"/> You take heart medications</p> <p>Other Health Issues <input type="checkbox"/> You have diabetes <input type="checkbox"/> You have asthma or other lung disease <input type="checkbox"/> You have burning or cramping sensation in your lower legs when walking short distances <input type="checkbox"/> You have musculoskeletal problems that limit your physical activity <input type="checkbox"/> You have concerns about the safety of exercise <input type="checkbox"/> You take prescription medication(s) <input type="checkbox"/> You are pregnant</p>	<p><i>If you marked any of these statements in this section, consult your physician or other appropriate health care provider before engaging in exercise.</i></p>
<p>Cardiovascular Risk Factors <input type="checkbox"/> You are a man older than 45 years <input type="checkbox"/> You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal <input type="checkbox"/> You smoke, or quit smoking within the previous 6 months <input type="checkbox"/> Your blood pressure is >140/90 mm Hg <input type="checkbox"/> You do not know your blood pressure <input type="checkbox"/> You take blood pressure medication <input type="checkbox"/> Your blood cholesterol level is >200 mg/dL <input type="checkbox"/> You do not know your cholesterol level <input type="checkbox"/> You have a close relative who had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister) <input type="checkbox"/> You are physically inactive (i.e. you get <30 minutes of physical activity on at least 3 days per week) <input type="checkbox"/> You are >20 pounds overweight</p>	<p><i>If you marked two or more of the statements in this section you should consult your physician or other appropriate health care provider before engaging in exercise.</i></p>
<p><input type="checkbox"/> None of the above</p>	<p><i>You should be able to exercise safely without consulting your physician or other appropriate health care provider.</i></p>

Signature of Applicant: _____ **Date:** _____
 (Parent or Guardian Signature required for applicants under the age of 18)