Health Directions
A Lexington Medical Center Health and Wellness Program
3239 Sunset Blvd, West Columbia, SC 29169
www.lmchealthdirections.com/workshops

For Office Use Only
Date: _____
Amt Paid: _____
Payment type: _____

Phone: (803) 791-2113
Fax: (803) 791-2299

Training and Development Registration Form

Name_____ Sex: M____ F____ DOB _____ Height_____ Weight_____

Address_____ City_____ State _____ Zip_____

E-mail address_____ Home/Cell Phone: _____ Alternate Phone: _____

Program Registration

___ American Heart Assoc CPR class

___ Communication is Crucial: Cultivating leadership, creating successful teams, building communities

___ Flex, Jab & Flow: Incorporating strength, focus and flexibility into one powerful workout

Medical History

1. Are you currently experiencing any health problems? Yes_____ No_____ If yes, describe_____
2. Do you smoke? Yes_____ No_____ If yes, specify how long and how much: _____
3. Do you have high blood pressure? Yes_____ No_____ (last reading): _____; Date_____; Medication_____
4. Do you have high cholesterol? Yes_____ No_____ (last reading): _____; Date_____; Medication_____
5. Have you been doing some type of exercise on a regular basis (2-3 times per week) over the last year? Yes_____ No_____

   If yes, please be specific: _____
6. Please check the appropriate spaces if they apply to you:

_____Heart Disease (Please be specific): _____ Medication: _____

_____Diabetes (Onset)_____ Medication: _____ Diet only: Yes_____ No_____

_____Stroke (Medication)_____ _____Orthopedic problems (Please be specific)_____

_____Asthma (Medication)_____ _____Arthritis/Bursitis (Please be specific)_____

_____Epilepsy (Medication)_____ _____Muscular weakness or injuries_____

_____Back Injury (Please be specific)_____ _____Allergies (Allergy medication): _____

_____Other medical problems/Meidcations (Please be specific): _____

7. Please check the appropriate spaces if you experience any of the following:

   ___Chest Pain ___Ankle swelling ___Shortness of breath ___Irregular Heartbeat ___Dizziness ___Heart murmur ___Fainting
8. Have you had any major illness or hospitalization within the last 6 months, including childbirth? ____Yes ____No

   If yes, please be specific: _____
9. Are you pregnant? _____No _____Yes / Due date: _____
10. What are your fitness goals? _____

_____

Consent for Participation

I, the undersigned applicant for and in consideration of the benefit to be derived by participation in the Health Directions class or program elected above, do hereby release and forever discharge Health Directions, its agents, servants, representatives, and staff from and against any and all liability and responsibility for any injury, illness or sickness which may result from participation in the Health Directions classes or programs elected, and do hereby further agree to indemnify and hold harmless Health Directions, its, agents, servants, and employees from any and all liability in such regard.

_____ _____

Applicant's Signature (if under 18, must be signed by parent or legal guardian) Date