

## Contact Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell/Home Number: (    ) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

I will be staying at (check one):    ☐ At home    ☐ Other location: Address provided below  
\_\_\_\_\_  
(If hotel, provide room #)***In Case of Emergency:***

Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell Number: (    ) \_\_\_\_\_ - \_\_\_\_\_ Work Number: (    ) \_\_\_\_\_ - \_\_\_\_\_

***Photo / Video Release & Permission:*** I grant to the Grand Forks Park District / Choice Health & Fitness, the right & license to take and publish photographs and/or video of me and/or my child in connection with my/our use of Grand Forks Park District facilities and during related activities. I further grant my permission of such photographs and/or video to be used for purposes such as publicity, illustration, advertising, and Web content consistent with the license granted above.

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

## HEALTH STATEMENT

***Read carefully and sign below. Parent must also sign if applicant is under 18 years of age***

As the undersigned applicant to the Choice Health & Fitness Lifeguarding or Water Safety Instructors course, I affirm that my participation is voluntary, and that I assume all risks for damage, injury, or loss to myself. I understand that the physical requirements of these courses are strenuous and vigorous. I confirm that my doctor has told me that my health and physical condition are adequate for my participation in this course without harm to myself; or, if I have not consulted my doctor, I hereby confirm that I was advised to do so by Choice Health & Fitness, and I accept all responsibility for not having done so. I further understand that Choice Health & Fitness is accepting me into the course(s) I have selected because of the statements I have set forth in this Health Statement.

Please answer the following medical history questions with a YES or NO.

**Have you ever, or do you currently have:**

- \_\_\_\_\_ Asthma or wheezing with breathing, or wheezing with exercise?
- \_\_\_\_\_ Frequent or severe attacks of hay fever or allergy?
- \_\_\_\_\_ Any form of lung disease?
- \_\_\_\_\_ History of chest surgery?
- \_\_\_\_\_ Epilepsy, seizures, convulsions, or take medications to prevent them?
- \_\_\_\_\_ History of blackouts, or fainting (full/partial loss of consciousness)?
- \_\_\_\_\_ History of diabetes? Type? \_\_\_\_\_
- \_\_\_\_\_ Inability to perform moderate exercise (swim 500 yards/meters within 12 minutes)?
- \_\_\_\_\_ History of high blood pressure or take medication to control blood pressure?
- \_\_\_\_\_ History of heart disease?
- \_\_\_\_\_ Other relevant physical or mental condition? Explain:
- \_\_\_\_\_

Applicant Name: \_\_\_\_\_

Date: \_\_\_\_\_

Applicant Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_