

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?
- _____ Recent tattoos or piercings (within 2 weeks)?
- _____ Other relevant physical or mental condition? Explain:

All medical information will be kept confidential and only released to responding emergency medical personnel.

Applicant Name: _____

Date: _____

Applicant Signature: _____

Parent/Guardian Signature: _____