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

___ Barbell Foundations Clinic

___ Apprenticeship Training Program: (Circle one)

Step Pilates Yoga Cardio Dance

Sculpt Cycle Low Impact

___ Intervals, Circuits & Boot Camps, oh my!

___ Kettlebell Clinic

___ Kettlebell Clinic 2: Doubles

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