

# UNIVERSITY FITNESS CENTER MEMBERSHIP APPLICATION

## CONTACT INFORMATION

Today's Date:

Last Name:

First Name:

Initial:

Current address:

City:

State:

ZIP:

Email:

Home Phone:

Work Phone:

Cell:

## EMPLOYEE INFORMATION

Current employer:  Penn State University  Hershey Medical Center

Department:

Lawson #

## COLLEGE OF MEDICINE STUDENT INFORMATION

Type of Student:  Medical Student  Graduate Student  Nursing Student

Projected Departure Date:

## MEMBERSHIP CATEGORY

Employee

PSU Medical /Graduate Student

Mohler Center Member

Volunteer

PSU Nursing Student

Physician Referred

Resident/Post Doctoral Scholar

Visiting Student

COM Alumnus

Community Partner *(Please list employer):*

If you are eligible for membership as a spouse or dependent of an employee, resident, student, or volunteer, please provide that individual's information below:

Name:

Phone:

Current UFC Member:  Yes  No

## PAYMENT METHOD

Payroll Deduction

Direct Pay (Quarterly/Semi-Annual/Annual)

Short Term

COM Student

## EMERGENCY CONTACT INFORMATION

Name:

Relationship:

Phone:

## PERSONAL PHYSICIAN INFORMATION

Name:

Address:

Phone:

**APPLICANT INFORMATION**

<input type="checkbox"/> Male	<input type="checkbox"/> Female	Age:
Height:	Weight:	Birth Date:
Are you currently physically active?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe your current activity:		
Have you <u>ever</u> used tobacco in any form?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes: <input type="checkbox"/> Smoke <input type="checkbox"/> Chew		How much (frequency/amount)?
How long have you used tobacco?		
If you do not currently use tobacco, when did you quit?		
Current daily caffeine intake: <input type="checkbox"/> None <input type="checkbox"/> <2 beverages <input type="checkbox"/> 2-5 beverages <input type="checkbox"/> 5-10 beverages <input type="checkbox"/> >10 beverages		
Current weekly alcohol use: <input type="checkbox"/> None <input type="checkbox"/> 1-2 beverages <input type="checkbox"/> 3-4 beverages <input type="checkbox"/> >5 beverages		
Are you currently on a weight loss diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you frequently alter your diet to lose weight?		<input type="checkbox"/> Yes <input type="checkbox"/> No

**MEDICAL HISTORY**

Check if you currently have, or have had a history of any of the following:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Abnormal Heart Rate	<input type="checkbox"/> Leg Cramps with Exercise
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Chest Pain/Pressure/Tightness	<input type="checkbox"/> Dizziness/Fainting with Exercise
<input type="checkbox"/> High Cholesterol (       )	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur or Rheumatic Fever	<input type="checkbox"/> Osteoporosis/Low Bone Density
<input type="checkbox"/> Muscular or Skeletal Injury or Disorder ( <i>Please describe</i> ):		
<input type="checkbox"/> Surgery or Hospitalization in Past Year ( <i>Please describe</i> ):		
<input type="checkbox"/> Allergies to Materials or Drugs ( <i>Please describe</i> ):		
<input type="checkbox"/> Current or Recent Pregnancy ( <i>Please list your actual or anticipated delivery month/yr</i> )		
<input type="checkbox"/> Other:		

**CURRENT MEDICATIONS**

Medication:	Reason:

**FAMILY HISTORY**

Please indicate if a blood relative has had any of the following:

<b>Condition</b>	<b>Relative</b>
<input type="checkbox"/> Heart Attack <u>Under Age of 55</u>	
<input type="checkbox"/> Angina/Chest Pain <u>Under Age of 55</u>	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> High Cholesterol	
<input type="checkbox"/> Sudden, Unexpected Death ( <i>Please explain</i> ):	

**INFORMATION VERIFICATION**

I have answered all of the above questions truthfully to the best of my knowledge.

Signature:	Date:

**CONFIDENTIALITY**

All information on this application is kept strictly confidential. Your information will be reviewed only by authorized employees of the Penn State University Fitness Center. This form will not be disclosed to third parties without your authorization, except as required by subpoena or other legal process.

**WAIVER OF LIABILITY**

Applicant understands that the Pennsylvania State University, through its University Fitness Center ("UFC"), offers exercise programs which involve physical stress and the use of potentially dangerous equipment. Applicant further understands that physical injury may result from the use of this equipment or involvement in exercise programs.

Therefore, it being the intent of the Applicant to hold The Pennsylvania State University, its trustees, officers, agents, and employees harmless, Applicant hereby releases, waives, and forever discharges the same from any and all liability suffered by Applicant related to use of the UFC. Applicant understands that he/she is using the equipment at his/her own risk. We recommend that all applicants become oriented with the equipment prior to use.

Applicant Signature:	Date:
Parent/Guardian Signature:	Date:

<b>OFFICE USE ONLY</b>		
	Orientation:	T:
Review:	Completed:	RA:
FD:	Pending:	T:
Mgmt:	Declined:	RA:
	Read Rules:	T: