FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

The Bangor Region YMCA
Biggest Mover Challenge Application
January 2019

Name: _________________________ Address: ________________________

Phone: ___________ Age: ________ E-Mail Address: _________________

Company: ____

T-Shirt Size: S M L XL XXL XXXL
Must register by January 10th to receive a shirt. Note: Shirts run about 1 size larger.

Please fill in SPECIFIC times that you are available for training. Thank you!

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Early Morning (5-8 am)							
Late morning (8 am-11 am)							
Early Afternoon (11 am-2 pm)							
Late Afternoon (2 pm-5 pm)							
Evening (5 pm-9 pm)							

THE BANGOR REGION YMCA
17 Second Street, Bangor ME 04401
P 207 941 2808 **F** 207 941 2812 www.BangorY.org

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Biggest Mover Challenge Questionnaire
January 2019

1. **What are your health & fitness goals? Be specific. What do you want to weigh? How do you want to feel?**

2. **Why do you want to achieve this goal or goals?**

3. **What have been the biggest challenges you have faced in the past?**

4. **What can we do to best serve you during this program?**

5. **Are you willing to give it your best effort?**

6. **What makes your soul sing on a daily basis? What do you love to do? What motivates & drives you ever day?**

7. **What one decision would you make in life if you knew you would not fail?**

8. **Any other additional notes/comments that you'd like to add?**

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YMCA PHOTO/AUDIO VISUAL/NARRATIVE RELEASE

I am 18 years of age or older and, if not, my parent or legal guardian has also provided their consent by signing below.

Consent & License. For my participation in activities to be conducted by the National Council of Young Men's Christian Associations of the United States of America ("YMCA of the USA") or any of its chartered member associations in the United States (collectively "the Y"), and collaborating third parties, I consent, now and for all time, to the making, reproduction, editing, broadcasting or rebroadcasting of:

- video film or footage of me,
- sound track recordings of me
- photo reproductions of me
- any narrative account of my experience

My consent includes a perpetual license to the Y and collaborating third-parties for the use of the above materials for publication, display, sale or exhibition in promotions, advertising, education and commercial uses. Use includes reproductions in any form and media currently existing or later conceived, adaptations and/or revisions, throughout the world in perpetuity.

I understand and agree there may be no additional compensation for this license, and I will not make any claim for payment of any kind from the Y or collaborating third-parties. I may, or may not be, identified in such licensed uses; however, my name will not be used to endorse any particular products or services.

Ownership, Confidentiality, and Shared Use. With respect to any of the above uses, I further agree:

- All works shall belong to YMCA of the USA;
- The Y has no duty of confidentiality regarding any licensed uses;
- YMCA of the USA shall exclusively own all known or later existing rights to the uses throughout the world;
- The Y and collaborating third-parties may use any video film, footage, sound track recordings and photo reproductions of me and/or my narrative account for any purpose without additional compensation to me.

Release from Liability. I agree that my consent is irrevocable. I hereby release and discharge The Y and collaborating third-parties, from any and all claims, actions, lawsuits or demands of any kind arising out of my consent, license grants, uses, or the shared uses of any works or materials referenced herein.

Signature: ____________________________________ Date: __________________

Printed Name: ________________________________ Age: ________

Address: ____

____

I am the parent or legal guardian of (child's name). I hereby consent and grant the licenses detailed in the foregoing on behalf of my minor child.

Signature of parent or legal guardian: ____

Printed name: ____

YMCA OF THE USA
101 N Wacker Drive, Chicago IL 60606
P 800 872 9622 F 312 977 9063 ymca.net

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The Bangor Region YMCA Health Information Form

The information requested below is necessary in order to provide each member with a safe and appropriate exercise experience. All information will be kept strictly **confidential.**

Name: (Last)___________________ (First)_____________________ (MI)_____ Today's Date ________
Daytime Phone: _______________________ Home Phone: _________________________
Address: ___________________________ City: ________________________ Zip: _______________
Email Address: ____ Gender: Male ___ Female ___
Date of Birth: _____________________ Age: ______ Height ____ ft ____inches
Weight:________

General Medical Information

Date of Last Checkup: ______________________________
Are you currently under a doctor's care? Yes ____ No ____ If yes, explain:
____
Please list all physicians you are currently under the care of:
Physician: _______________________________________ Specialty:____________________________
Address: ____
Phone: ____________________________________

Most Recent Blood Pressure Reading: ______/______ Date: _____________________

Do you currently exercise? Yes __ No __ If yes, please list activities and other recreational pursuits:
____

Would you like more information about:
___ Orientation
___ Personalized Exercise Program
___ Personal Training
___ Personal Training in the pool
___ Biggest Mover

Do you accumulate 30 minutes or more of moderate physical activity on most days of the week? Y _N _
Does your job require you to sit or stand in one place for the majority of the time? Y __ N __

Have you ever had a stress test? Yes ___ (If yes, date: ___/___/___) No __ Don't know __
If yes, were the results: Normal ___ Abnormal ___ Don't know ___
Blood pressure response to exercise: Normal ___ Abnormal ___ Don't know ___

Do you take any medications on a regular basis? Yes ___ No ___
If yes, please list medications, dosage, and REASON FOR TAKING
________________________________ ___________________________________
________________________________ ___________________________________

If needed, can we call your physician for more information (please initial) _______
____ Yes, I give you my approval to contact my physician
____ No, I'd like to speak with you prior to contacting my physician

Office Use Only:

If you have been or are presently being treated for any of the following conditions please check yes or no. If you answer yes to any of those with an asterisk, please answer the appropriate section(s) on the following pages.

YES NO

___ ___ Heart disease: (circle) heart attack, bypass, cardiac surgery, artery disease, heart valve problems

___ ___ Congenital heart disease

___ ___ Rheumatic heart disease

___ ___ *Chest, neck, jaw, or arm pain/pressure/tightness/heaviness: with exertion __ at rest __

___ ___ Abnormal resting Electrocardiogram

___ ___ *Heart murmur

___ ___ *Irregular heart beat: rapid ___ slow ___ skipped beats ___ extra beats ___

___ ___ Stroke (if yes, date: ___/___/___)

___ ___ *Diabetes (fasting blood glucose ____mg/dl)

___ ___ *Other metabolic disease: thyroid ___ liver ___ kidney ___ other ___

___ ___ Epilepsy

___ ___ Abnormal blood pressure response to exercise

___ ___ High blood pressure (___/___ mm Hg)

___ ___ Elevated Cholesterol (>200 total, HDL <35, LDL > 130 or on cholesterol lowering medication):

Total: _____ mg/dl HDL _____ mg/dl LDL _____mg/dl

___ ___ Elevated triglycerides (present # ____/____mg/dl)

___ ___ Smoke cigarettes

___ ___ Quit smoking within the last 6 months

___ ___ Diagnosed hypoglycemia

___ ___ Anemia

___ ___Asthma: (if yes, please explain: ____)

___ ___ Obesity

___ ___ Pregnant (if yes, dates: ____)

___ ___ Osteoporosis

___ ___ *Arthritis

___ ___ *Joint or muscle pain/injury

___ ___ *Back pain or injury: upper back ___ middle back ___ lower back ___

___ ___ *Lightheadedness ___ or Fainting ___ (whichever applies)

___ ___ *Serious Illness

___ ___ *Surgery

___ ___ *Hospitalization

<u>Family History:</u>

(parents, siblings, or children before 55 years of age for males and before 65 years of age for females)

YES	NO		Family Member	Age of Onset
___	___	Heart disease (circle) heart attack, bypass surgery, cardiac surgery, artery disease	_______	______________
___	___	Sudden death	______________	____________
___	___	Congenital heart disease	______________	____________
___	___	Stroke	______________	____________

I understand that I am participating in an exercise program at my own risk and under the same terms mentioned on the membership form. I attest that I have voluntarily provided information for this form and that it is true to the best of my knowledge. I understand that I am responsible for updating this form annually or as health information changes, whichever comes first. I give employees of the Bangor Region YMC permission to review my health information provided on this form. I understand that completion of this form does not impose any liability or obligation upon the Bangor Region YMCA.

Signature ___________________________ Date ___/___/___ Witness __________ Date ___/___/___

Signature of Parent/Guardian if under 18 __________________________________ Date ___/___/___

If you checked yes to conditions with an asterisk (*), please elaborate as much as possible. Please feel free to use the back if necessary.

1. Chest pain/pressure/tightness/heaviness
   Explain: ____

2. Heart murmur
   What is the diagnosis? ______________________________________
   When was it diagnosed? ____/____/____
   Is the condition still present? Yes ____ No ____
   How was it diagnosed? Stethoscope ____ Echocardiogram ____ Other ________________
   Have you been restricted or limited in any way by your doctor Yes ____ No ____
   If yes, explain:____

3. Irregular heart beat
   Explain: ____

4. Diabetes
   Do you take insulin shots? ____________________
   Is it controlled by diet? ______________________
   Any restrictions/limitations? __________________
   Any other important information? ______________________________
   Do you take medications? If so, what? ___________________________

5. Metabolic Disease
   When were you diagnosed? ____/____/____
   Is the condition still present? Yes ____ No ____
   Any restrictions/limitations? ___________________________________

6. Arthritis
   Where is it located? ____
   Has it been diagnosed by a doctor? _______________
   Any restrictions/limitations? ___________________________________
   Are there certain activities which aggravate the condition? ____________________

7. Joint or muscle pain/injury
   Which joint? ________________ Which muscle? _________________________
   When and how did the injury occur? ______________________________
   What type of doctor was seen? General Practitioner __ Orthopedist __ Physical Therapist __Other __
   What was the diagnosis? _______________________________________
   Are you still in treatment? ______________________________________
   Any restrictions/limitations? ____________________________________

8. Back pain/injury
   Describe pain ____
   What type of doctor was seen? General Practitioner __ Orthopedist __Physical Therapist __Other __
   What was the diagnosis? _______________________________________
   Are you still in treatment? ______________________________________
   Any restrictions/limitations? ____________________________________

9. Lightheadedness or fainting
   What is the cause? ____
   Have you seen a doctor? __________________
   How long have you had this condition? _______________
   How often do episodes occur? _____________________________________

10. Allergies – What are they? _______________________________________
    Please provide any other details ___________________________________

11. Serious Illness
    Please describe (what, when): ______________________________________
    ____

12. Surgery – Please describe (what, when): ____________________________
    ____

13. Hospitalization – Please describe (what, when): _______________________
    ____