FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Bangor Region YMCA
Summer Shape-Up Application
2019

Name: ________________________ Address: ________________________

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

TANK Size: S M L XL XXL XXXL

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)							

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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:

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

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): ______________________________
    ____