YWCA LOWER CAPE FEAR

2815 S College Rd Wilmington, NC 28412

(910) 799-6820

FLOW MOTION REGISTRATION

APPLICANT INFORMATION

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ Email _____

Mobile Phone: _____ Birthdate: _____

Emergency Contact Name/Relation/Phone: _____

Preferred Method of Contact EMAIL ☐ PHONE ☐

Are you a current member of the YWCA? YES ☐ NO ☐

Have you participated in this program in the past? YES ☐ NO ☐

NEXT STEPS

☐ **CONSENT FORM**

☐ **HEALTH HISTORY & FLOW MOTION ASSESSMENT**

☐ **YWCA MEMBERSHIP FORM**

☐ **MEDICAL CLEARANCE FORM OR DOCTOR'S LETTER OF PERMISSION**

DISCLAIMER AND SIGNATURE

I submit this registration form and the enclosed documents for the Flow Motion program, its instructors and administrators. To the best of my knowledge, I attest that I am physically fit to participate in the activities for which I am enrolling.

Signature: _____ Date: _____

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FLOW MOTION CONSENT FORM

I, hereby accept all risks associated with my participation in the Flow Motion fitness program and release and further discharge the trainers, volunteers and anyone associated with the YWCA Lower Cape Fear, Inc. from any and all responsibilities or liability from injuries or damages resulting from or connected with my participation in any of the exercise programs whether arising from the negligence of the RELEASES or otherwise.

I hereby assume full responsibility for all the forgoing risks, known and unknown, and accept responsibilities for the damage following any injury, permanent disability or death.

YWCA Lower Cape Fear, Inc, staff and or volunteers will implement the most effective principles to help the participant achieve his or her goals within the instructor's scope and practice, but cannot guarantee that tis products or workouts will be safe, effective or suitable for everyone. For that reason, all such products, services, programs, techniques and materials embodied in such products and services are offered without warranties or guarantees of any kind, expressed or implied and the instructor and/or staff/volunteer's disclaim any liability, loss or damages that may result from their use.

I understand that a physician's approval is highly recommended prior to participating in this program and have either obtained a signed approval from my physician or have signed the acknowledgement of risks without a Medical Release Form and if I meet the criteria of the Flow Motion Fitness Program.

I hereby accept all risks associated with all sites and locations provided for use of the Flow Motion fitness program, including the YWCA Lower Cape Fear, Inc.

I have read this document in its entirety and agree to adhere to all its precepts, as well as all other terms and conditions of the Flow Motion fitness program. I understand the risks and benefits of the program. Any questions that I may have had have been answered to my satisfaction. Upon participation, I do hereby discharge, release and hold harmless the instructor, volunteers, staff and anyone involved with the YWCA Lower Cape Fear, Inc. from all liability for damage claims or losses of any kind of character whatsoever resulting from any injury or condition I may suffer or resulting from my participation except if such damage(s) or injury(s) are primarily the direct result of gross negligence or misconduct of the Releases and not caused on my own negligence.

Signature: _____ Date: _____

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FLOW MOTION MEDICAL CLEARANCE FORM

DEAR DOCTOR:

Your patient _____ wished to take part in an exercise program and/or fitness assessment. The exercise program may include progressive resistance training, flexibility exercises and a cardiovascular program; increasing in duration and intensity over time. The fitness assessment may include a sub-maximal cardiovascular fitness test and measurements of body composition, flexibility and muscular strength and endurance.

After completing a readiness questionnaire and discussing their medical condition(s) we agreed to seek your advice in setting limitations to their program. By completing this form, you are not assuming any responsibility for our exercise and assessment program. Please identify any recommendations or restrictions for your patient's fitness program below.

PATIENT'S MEDICAL RELEASE CONSENT

I consent to and authorize _____ (DOCTOR'S NAME) to release health information concerning my ability to participate in an exercise program and/or fitness assessment to the **YWCA – FLOW MOTION PROGRAM**. I understand this consent is revocable except to the extent action has already been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of person to whom it pertains.

MEMBER'S SIGNATURE: **DATE:**
TRAINER'S SIGNATURE:

PHYSICIAN'S RECOMMENDATIONS

□ I am not aware of any contraindications toward participation in a fitness program.

□ I believe the applicant can participate, but urge cautions in these areas:

□ The applicant should NOT engage in the following activities:

□ I recommend this applicant NOT participate in the above fitness program

Physician's Signature: _____ **DATE:**_____

Physician's Name [PRINT] : _____ **PHONE:**

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FLOW MOTION HEALTH FORM

DATE:

GENERAL INFORMATION

NAME:
DATE OF BIRTH:
AGE:

EMAIL:
GENDER:
HEIGHT/WEIGHT:

PHYSICIAN'S NAME:
DATE OF LAST PHYSICAL EXAM:

PHONE:

Does Your physician know that you are participating in an exercise program: □ YES □ NO

HISTORY

Please indicate any and all of the indications that you have now or have had in the past:

□ *Heart Problems*
□ *Chronic Illness:*
□ *Diabetes*
□ *Thyroid Disease*
□ *Swollen, Stiff or Painful Joints*
□ *Auto-Immune Disease:*
□ *Asthma or COPD*
□ *Increased Blood Pressure*
□ *Vision Loss*
□ *Hearing Loss*
□ *Hernia*
□ *Back Problems*
□ *Breathing or Lung Problems*
□ *Foot Problems*

Y/N Do you ever get dizzy, lose your balance or lose consciousness?
Y/N Have you had difficulty with physical exercise?
Y/N Have you been advised by physician not to exercise?
Y/N Have you had surgery within the past 6 months?
Y/N Are you a cigarette smoker?

Do you have any other medical conditions or problems not mentioned above? If so, please list them here. You may want to include allergies or dietary restrictions as well.

Please list current medications:

EXERCISE & PHYSICAL ACTIVITY HISTORY

Y/N Are you currently involved in a regular fitness program?

Y/N Are you involved in physical activities of daily living?

Y/N Are you involved in a strength training/weight lifting program?

Y/N Are you involved in a cardiovascular exercise or a group fitness program?

Y/N Are you involved in any sports? If so, which ones and how often:

DO YOU CONSIDER YOURSELF:

- □ SEDENTARY
- □ LIGHTLY ACTIVE
- □ MODERATELY ACTIVE
- □ HIGHLY ACTIVE

DO YOU CONSIDER YOUR LEVEL OF FITNESS:

- □ NOT FIT
- □ LESS THAN AVERAGE
- □ AVERAGE
- □ ABOVE AVERAGE
- □ OUTSTANDING
- □ DON'T KNOW

WHAT IS THE MAIN REASON YOU EXERCISE OR WANT TO BEGIN EXERCISE?

- □ GOOD FOR MY HEALTH
- □ DOCTOR ADVISORY
- □ TRYING TO LOSE WEIGHT
- □ HELPS TO RELIEVE STRESS
- □ MAKES ME FEEL GOOD
- □ OTHER

WHAT ACTIVITIES WOULD/DO YOU PREFER IN A REGULAR EXERCISE PROGRAM:

- □ WALKING
- □ RUNNING
- □ SWIMMING
- □ INDOOR CYCLING
- □ OUTDOOR CYCLING
- □ STRETCH/YOGA
- □ STRENGTH/RESISTANCE TRAINING
- □ RACQUETBALL
- □ PICKLEBALL
- □ TENNIS
- □ BASKETBALL
- □ PILATES
- □ GROUP FITNESS CLASSES (ZUMBA, STEP AEROBICS, BOOTCAMP)
- □ OTHER:

BREAST CANCER HEALTH HISTORY

WHAT WAS YOUR DIAGNOSIS:

WHAT KIND OF BREAST CANCER SURGERY DID YOU HAVE? WHAT MONTH/YEAR?

WERE LYMPH NODES REMOVED?

WHAT KIND OF THERAPY DID YOU RECEIVE?

WHAT THERAPY ARE YOU CURRENTLY RECEIVING?

WHERE ARE YOU IN TREATMENT?

ARE YOU EXPERIENCING ANY SIDE EFFECTS FROM YOUR TREATMENT? IF YES, PLEASE LIST:

HOW DO THEY AFFECT YOUR PHYSICAL ACTIVITY?

WHAT DO YOU DO TO MAKE THE SIDE EFFECTS BETTER?

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

WERE YOU INVOLVED IN A PHYSICAL THERAPY PROGRAM AFTER YOUR TREATMENT?

HAVE YOU OR WILL YOU BE UNDERGOING BREAST RECONSTRUCTION IN THE NEXT 12 MONTHS? If yes, please indicate type and approximate date.

Signature: _____ Date: _____

YWCA Lower Cape Fear

Mission Membership Information Card

eliminating racism empowering women
ywca

☐ Kintera ☐ QuickBooks

This Box Office Use Only

Date _____

Receipt # _____

Name _____ Birth Date ____/____/____
First Middle Initial Last

Address _____ Apt/Suite _____

City _____ State _____ Zip _____ County _____

Primary Phone _____ Email _____

Employer _____ Phone _____

Preferred Method of Contact? ☐ Cell/Phone ☐ Email ☐ Work Phone ☐ US Postal Service

Spouse's Name _____ Children _____ Age ____

_____ Age ____

_____ Age ____

Emergency Contact _____

Contact Phone _____ Household Income ☐ 0-20,000 ☐ 21,000-40,000

☐ 41,000-80,000 ☐ 81,000 & Up

Relation to Contact _____

How did you hear about the YWCA Lower Cape Fear? ☐ Friend ☐ Facebook ☐ Website ☐ Other_____

In case of accident, I authorize the YWCA to provide first aid and emergency medical care which may include the services of a doctor and hospital. I am willing to participate in any media coverage of the YWCA

To the best of my knowledge, we are physically fit to participate in the activities for which we are enrolling. We agree to indemnify the YWCA Lower Cape Fear, Inc., it's officers, coordinators, directors, members, agents, employees and instructors from and against all claims, demands and liability whatsoever arising out of the operation of the YWCA Lower Cape Fear, Inc.

Signature _____ Date ____/____/____

✓ *Please Check Boxes Below*

Race:

- ☐ White
- ☐ African American
- ☐ Native American
- ☐ Hispanic
- ☐ Asian
- ☐ Other

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widow/Widower

Membership Type:

☐ Individual	$35.00
☐ Family	$55.00
☐ Senior	$30.00
☐ Youth	$25.00

Individual	Ages 18 - 59
Youth	Ages 2 - 17
Senior	Ages 60 & up