

WAIVER, RELEASE OF LIABILITY, AND ASSUMPTION OF RISK

When used properly, the facilities and activity programs offered by the Student Health and Wellness Center have been designed to provide the optimum level of beneficial exercise and enjoyment. Inherent in any exercise program, however, is the risk of injury through improper use of the equipment or imprudent exercise beyond your capability. Prior to beginning this program, you will be instructed in the proper use of all equipment and will be taught how to monitor your heart rate and minimize any risk on the part of the Health and Wellness Center. It is important that you learn these tasks and faithfully and regularly incorporate them into your exercise program.

Since many individuals are unaware of the state of their physical health, it is recommended that you consult with your physician before engaging in any activities that are part of the Fitness Program.

In consideration of the above factors, I, the undersigned participant, acknowledge the existence of risks connected with the exercise programs and activities that take place in the Health and Wellness Center. I agree to assume such risks and agree to accept the responsibility for any injuries sustained by me or my dependents in the course of using the facilities and equipment. More specifically, I acknowledge and accept responsibility for injuries arising out of those activities that involve risks in one or more of the following general areas:

- (a) the use of exercise equipment;
- (b) participation in the unsupervised activities which are made available on the running track, in the gym, and in other individual or group exercise activities;
- (c) participation in individual or joint exercising which could result in such injuries or disorders as heart attack, stroke, heat stress, sprains, broken bones, torn muscles, torn ligaments, etc.
- (d) accidents occurring within the auxiliary facilities such as locker rooms, dressing rooms and showers.

I further acknowledge the existence of and need for certain rules and procedures concerning the use of the equipment, facilities and activities of the Health and Wellness Center. I agree to abide by those rules and procedures and shall make every effort to ensure that the equipment and facilities are kept in a safe and useable condition.

HAVING READ THE FOREGOING, I ACKNOWLEDGE MY UNDERSTANDING OF THOSE RISKS SET FORTH ABOVE AND KNOWINGLY AGREE TO ASSUME FULL RESPONSIBILITY FOR SAME.

Dated this _____ day of _____, 20_____.

Participant Signature: _____
 Spouse Signature: _____
 Dependant 1 Signature: _____
 Dependant 2 Signature: _____
 Dependant 3 Signature: _____
 Wellness Center Official: _____



MEMBERSHIP APPLICATION

PRIMARY PARTICIPANT (REQUIRED)

AAMU STUDENT
 FACULTY & STAFF
 ALUMNI
 COMMUNITY
 SENIOR
 AFFILIATE _____
 CORPORATE _____

Last Name: _____ First Name: _____ MI: _____
 Street Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Email: _____ Gender: _____
 AAMU Graduate Year: _____ Current Occupation: _____ Company Name: _____ Business Phone: _____
 Birth date: ____/____/____ Affiliate/Corporate Organization (if applicable): _____

WHERE DID YOU HEAR ABOUT US?

Friend (Name: _____)
 Print advertisement Radio advertisement
 Web site Other: _____

FEES & PAYMENT

Membership \$ _____
 TOTAL \$ _____

Payment (non-refundable) is due at time of registration.
 Make checks payable to: AAMU
 for: Student Health & Wellness Center

FOR OFFICE USE ONLY

PLEASE CIRCLE ONE:
 MONEY ORDER CASHIERS CHECK PERSONAL CHECK
 CASH CHECK #: _____

Current AAMU Student Eligibility Verified Y N
 ___ Plus Spouse ___ Family Request Approved Y N
 Faculty and Staff Membership Entered Y N
 ___ Ind ___ Plus Spouse ___ Family
 Alumni Membership #
 ___ Ind ___ Plus Spouse ___ Family Primary: _____
 Community Spouse: _____
 ___ Ind ___ Plus Spouse ___ Family Dependant 1: _____
 Senior Dependant 2: _____
 ___ Ind ___ Plus Spouse Dependant 3: _____
 Affiliate
 ___ Ind ___ Plus Spouse ___ Family Staff: _____
 Corporate Date: _____
 ___ Ind ___ Plus Spouse ___ Family

ADDITIONAL FAMILY MEMBER DEPENDANTS

***Must be under the age of 18 years old to be considered a dependant**

Last Name: _____ First Name: _____ MI: _____
 Birth date: _____ Gender: _____
 Last Name: _____ First Name: _____ MI: _____
 Birth date: _____ Gender: _____
 Last Name: _____ First Name: _____ MI: _____
 Birth date: _____ Gender: _____

PRIMARY PARTICIPANT

YOUR HEALTH AND FITNESS

Physician Name: _____ Physician Phone: _____ Date of Last Physical: _____

Do you have any health conditions? (Please circle) YES or NO

If you answered yes to the above questions please explain:

List all drugs/medications you are taking and the reason:

1. _____ 2. _____ 3. _____

Are you aware of any allergies to any medications? Y N If yes, please list: _____

Do you know your resting blood pressure? If yes: _____ / _____

Are you presently involved in a regular exercise program? YES NO

If yes, please list activities/duration/frequency/intensity _____

How would you characterize your life? (Please Circle) Low Stress Moderate Stress High Stress

Are there any other comments you would like to give concerning your health or fitness goals?

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate medical history report.

Participant Signature

Date

SPOUSE

YOUR HEALTH AND FITNESS

Physician Name: _____ Physician Phone: _____ Date of Last Physical: _____

Do you have any health conditions? (Please circle) YES or NO

If you answered yes to the above questions please explain:

List all drugs/medications you are taking and the reason:

1. _____ 2. _____ 3. _____

Are you aware of any allergies to any medications? Y N If yes, please list: _____

Do you know your resting blood pressure? If yes: _____ / _____

Are you presently involved in a regular exercise program? YES NO

If yes, please list activities/duration/frequency/intensity _____

How would you characterize your life? (Please Circle) Low Stress Moderate Stress High Stress

Are there any other comments you would like to give concerning your health or fitness goals?

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate medical history report.

Participant Signature

Date

DEPENDANT 1

YOUR HEALTH AND FITNESS

Physician Name: _____ Physician Phone: _____ Date of Last Physical: _____

List any health conditions you may have including drugs/medications you are taking:

Are you aware of any allergies to any medications? Y N If yes, please list: _____

Are you presently involved in a regular exercise program? (Please circle) YES or NO

If yes, please list activities/duration/frequency/intensity _____

Are there any other comments you would like to give concerning your health history or fitness goals?

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate medical history report.

Participant Signature

Date

DEPENDANT 2

YOUR HEALTH AND FITNESS

Physician Name: _____ Physician Phone: _____ Date of Last Physical: _____

List any health conditions you may have including drugs/medications you are taking:

Are you aware of any allergies to any medications? Y N If yes, please list: _____

Are you presently involved in a regular exercise program? (Please circle) YES or NO

If yes, please list activities/duration/frequency/intensity _____

Are there any other comments you would like to give concerning your health history or fitness goals?

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate medical history report.

Participant Signature

Date

DEPENDANT 3

YOUR HEALTH AND FITNESS

Physician Name: _____ Physician Phone: _____ Date of Last Physical: _____

List any health conditions you may have including drugs/medications you are taking:

Are you aware of any allergies to any medications? Y N If yes, please list: _____

Are you presently involved in a regular exercise program? (Please circle) YES or NO

If yes, please list activities/duration/frequency/intensity _____

Are there any other comments you would like to give concerning your health history or fitness goals?

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate medical history report.

Participant Signature

Date