

OFFICE USE ONLY  
Data entry by \_\_\_\_\_

OFFICE USE ONLY  
Initials of staff member  
accepting form \_\_\_\_\_

## CAMPBELL SPORTS CENTER HEALTH HISTORY

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_

ID#: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Circle one:      Student                                  Fac/Staff  
F/S Spouse/Partner (check one) Eligible for benefits \_\_\_\_\_ not eligible \_\_\_\_\_  
Contract Service Employee: (**circle one**) AVI Fresh/ABM/Follett/Flora/Ricoh  
Alumnae/I                                  Alum Spouse                                  Student Spouse  
Other: \_\_\_\_\_

OFFICE USE ONLY  
Fee  
Collected \_\_\_\_\_

Emergency Contact:      Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### PERSONAL HISTORY

Have you had or do you have: (check all that apply)

_____ Angina	_____ Asthma	_____ Heart Attack
_____ Epilepsy/Seizure	_____ Emphysema	_____ Heart Valve Defects
_____ High Blood Pressure	_____ Diabetes	_____ Heart Disease
_____ High Cholesterol	_____ Major Surgery	_____ Eating Disorder
_____ Allergies		

*\*If any of the above are checked, please give details on the reverse side of this form.*

Please list and describe any medical conditions that may prevent you from exercising safely:

\_\_\_\_\_

Is there anything you would like our staff to be aware of while you exercise at the Campbell Sports Center? If yes please describe: \_\_\_\_\_

\_\_\_\_\_

Please list any medications you are presently taking:

Medication: \_\_\_\_\_ Reason: \_\_\_\_\_

Medication: \_\_\_\_\_ Reason: \_\_\_\_\_

I certify that the above information is complete and accurate. I understand that I exercise at my own risk. I understand that fitness activities are designed to place a gradually increasing workload on the circulation and to thereby attempt to improve its function. The reaction of the cardiovascular system to such activities cannot be predicted with complete accuracy. There is a risk of certain changes occurring during or following the exercise. These changes include abnormalities of blood pressure and/or heart rate, or ineffective "heart function" and possibly, in some instances, a "heart attack" or cardiac arrest. I realize that it is necessary for me to promptly report to the staff any signs or symptoms indicating any abnormality or distress. I consent to the administration of any immediate resuscitation measures deemed advisable by the staff.

I understand that the Department of Physical Education and Athletics reserves the right to limit my activity and/or deny access to the Sports Center if my conduct or behaviors are deemed to be unsafe, inappropriate or dangerous to my health. I understand that the Department may require a full health assessment at any time as a condition for using the facility. I give permission to the Department of Physical Education and Athletics to discuss my health status with Health Services at any time.

I have read and understand this form completely. Any questions which have occurred to me have been answered to my satisfaction. I assume responsibility for my physical condition and health prior to, during and after the use of the Campbell Sports Center and all the equipment therein, hereby indemnifying the Campbell Sports Center, the employees, and Sarah Lawrence College from any claims.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_