

Medical Information Form *(if Participating in an Exercise Program at the Facility)*

Please complete the medical questionnaire below with information concerning you and your medical history. Your response will help us assist you in obtaining any needed medical care and contacting your family in the event of an emergency. Please answer each section carefully with current information. All information will remain confidential with your Senior Circle Chapter and will be used only in case of an emergency.

Name:		Date:
Address:		
City, State, Zip:		
Physician Name:		
Physician Address:		Physician Area/Phone #:
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		Birthdate: Month ____ Day ____ Year ____
Past Medical History: <i>(List any medical conditions you currently have, especially those currently under medical treatment.)</i>		
Do you have any conditions that would limit your participation in fitness exercise or dance programs? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, please fill out a physician waiver.)</i>		
Allergies:		
EMERGENCY CONTACT INFORMATION		ADDITIONAL EMERGENCY CONTACT INFORMATION
Contact Name:		Contact Name:
Area/Phone Number:		Area/Phone Number:
Address:		Address:
City:	St:	Zip:

This form expires 3 years from completion date and must be renewed for continued participation.