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## JUNIOR INFORMED CONSENT FOR EXERCISE PRESCRIPTION & TESTING

Full Name of Student: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Grade: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ E-mail: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### MEDICAL HISTORY

Have you ever been hospitalized?	YES	NO
Have you ever had surgery?	YES	NO
Are you currently taking any medication?	YES	NO
Do you have any allergies? (Meds, bees, etc.)	YES	NO
Have you ever passed out during exercise?	YES	NO
Have you ever experienced dizziness during exercise?	YES	NO
Have you ever experienced chest pain?	YES	NO
Have you ever been told that you have high blood pressure?	YES	NO
Have you ever been told that you have low blood pressure?	YES	NO
Do you have a heart murmur?	YES	NO
Has anyone in your family died of heart related complications before the age of 40?	YES	NO
Do you have any skin problems such as itching, break outs, rash?	YES	NO
Have you ever had a head injury?	YES	NO
Do you or have you ever had seizures?	YES	NO
Have you ever had a stinger or a burner?	YES	NO
Have you ever had any injuries? (broken bones, dislocations, sprains, stitches, etc.)	YES	NO
Have you ever had heat cramps or experienced any kind of heat related illness?	YES	NO
When was your last tetanus shot? _____		

**Please explain in detail any YES answers that are circled:**

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**Have you ever had: (check all that apply)**

Fainting	_____	Poliomyelitis	_____
Diphtheria	_____	Pneumonia	_____
Scarlet Fever	_____	Asthma	_____
Rheumatism	_____	Diabetes	_____
Rheumatic Fever	_____	Heart Disease	_____
Kidney Disease	_____	Hepatitis	_____
Tuberculosis	_____	Jaundice	_____
Rupture	_____	Mononucleosis	_____

**Do you currently have:**

Blurred Vision \_\_\_\_\_  
Headaches \_\_\_\_\_  
Convulsions \_\_\_\_\_  
Blackouts \_\_\_\_\_  
Shortness of Breath \_\_\_\_\_  
Frequent Urination \_\_\_\_\_  
Cough \_\_\_\_\_  
Nosebleeds \_\_\_\_\_  
Frequent Sore Throats \_\_\_\_\_  
Stomach pains \_\_\_\_\_  
Stomach Ulcer \_\_\_\_\_

**Please explain in detail any ailments that are checked:**

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#### **Parent/Guardian Informed Consent**

I, \_\_\_\_\_, the parent/legal guardian of \_\_\_\_\_, hereby state that to the best of my knowledge, \_\_\_\_\_ has no medical or physical conditions that may affect or restrict him/ her from participating in various fitness testing and exercise programs. I agree to assume any and all risks of such exercise and testing and further agree to hold Rachel Webster Personal Fitness from any and all claims, suits, losses or related causes arising in any way from the exercise and testing programs. I also recognize that as a result of participating in such exercise activities, medical treatment on an emergency basis may be necessary and further recognize that Rachel Webster Personal Fitness personnel may be unable to contact me for my consent for emergency medical care, including EMT and hospital care, as may be deemed necessary under possible emergency circumstances and to assume the expenses of such care. I understand the risks my child may incur due to answering any of the above medical questions inaccurately. In signing this consent/clearance, I affirm that I have read this form in its entirety and that I understand the nature of the exercise and testing and the risks involved. I also affirm that my answers to all of my questions concerning this form, the exercise and testing have been answered to my satisfaction.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Junior Participant: \_\_\_\_\_ Date: \_\_\_\_\_

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