



Class Information:

Instructor: _____

Location: _____

Fee: \$ _____

Stay Strong, Stay Healthy Registration

Name: _____

Phone number: _____

Email/Address: _____

Has a physician ever said you have a heart condition and that you should only perform physical activity recommended by a physician? **YES / NO**

Do you feel pain in your chest during physical activity? **YES / NO**

In the past month, have you had chest pain at a time when you were not doing physical activity? **YES / NO**

Do you ever lose consciousness or do you lose your balance because of dizziness? **YES / NO**

Signature: _____

Medical Care Provider Information

Name: _____

Hospital/Clinic Affiliation: _____

Do you have bone or joint problems (back, knee or hip) that may be made worse by a change in your physical activity? **YES / NO**

Is a physician currently prescribing medication for your blood pressure or a heart condition? **YES / NO**

Are you 69 years of age or older? **YES / NO**

Do you know of any other reason why you should not exercise or increase your physical activity? **YES / NO**

Date: _____

Phone: _____

Fax: _____

For potential participants responding “yes” to any of the eight questions, we strongly request that a doctor complete a Physician Authorization Form before beginning a Stay Strong, Stay Healthy class.

For instructor use. Valid for one year.