San Jose State University Timpany Center

Personal Training Program

Liability Release

First Name | Last Name | Date

I understand and agree that the Timpany Center is an educational training facility not a medical facility and does not provide medical treatment. The primary focus is to provide individualized exercise programs for the purpose of improving physical fitness.

I understand and agree that my participation in the exercise program may involve the use of exercise equipment and will add stress to my body thereby exposing me to the risk of injury or even death. By signing the consent form I am acknowledging that I have read, understand and am willing to accept the risks.

Furthermore, I do hereby irrevocably and personally release, hold harmless and forever discharge San Jose State University Research Foundation: Timpany Center, and every office, agency, employee and student from all claims, causes of action, or liability of every kind which I may have in the future or that any person claiming through me may have in the future against agencies listed above by reason of any injury to person or property, or death, in connection with my participation in Timpany Center Training Program.

I am 18 years or older. I have read this document, and I am signing it freely. I understand the legal consequences of signing this document, including (a)releasing the University from all liability, (b)waiving my right to sue the University, (c)and assuming all risks of participating in this activity, including travel to and from the activity or any events incidental to this activity.

I understand that this document is written to be as broad and inclusive as legally permitted by the State of California. I agree that if any portion is held invalid or unenforceable, I will continue to be bound by the remaining terms.

Client's Name | Date

Client's Signature | Date

Medical Disclosure

The Timpany Center is designing an exercise program, the programs may include exercises for improved muscular strength, range of motion, cardiovascular endurance, posture and balance.

The Timpany Center requests that you provide any medical information, which would affect the selection of activities performed during training sessions. Thank you for your assistance.

____

First Name Last Name Date of Birth

Physical Disability:____

Medical Diagnosis:____

Prone to Seizures: ____No ____Yes, frequency of seizures____________________________________

Please check off any of the following activities your physician has recommended you refrain from:

Fitness Center exercise program	Aquatic exercise program
☐ Strength training exercises	☐ Strength training exercises
☐ Weight bearing exercises	☐ Assistive weight bearing
☐ Stretching exercises (active/passive)	☐ Stretching exercises (active/passive)
☐ Cardiovascular exercise	☐ Cardiovascular exercise
	☐ Submersion
	☐ Deep water exercise

Please give a brief explanation for the above restrictions and/or if your physician has given any alternative

recommendations.(ex: Max working out heart rate) ____

____

____

____(_____)_______________________

Name of primary physician Phone Number

____

Client's Name Date

____

Client's Signature Date

Health Information Form

First Name	Last Name		Date
Address	City	State	Zip
Home Phone	Cell Phone	Email	
Date of Birth	Age	Gender	Language(s)

Emergency Contact:

Name	Relation	Phone
Name	Relation	Phone

Physician(s) Information:

Primary Physician	Specialization	Phone	
Address	City	State	Zip
Email		Date last seen	
Secondary Physician	Specialization	Phone	
Address	City	State	Zip
Email		Date last seen	

Medications:

Name	Purpose	Dosage
Name	Purpose	Dosage
Name	Purpose	Dosage

Hospitalizations:

Date(s)	Hospital	Reason	Length of Stay
Date(s)	Hospital	Reason	Length of Stay
Date(s)	Hospital	Reason	Length of Stay

Please complete the following questions:
Describe injury or disability(include date of injury and diagnosis):____________________________________

____
____
____
____
____

List therapies and the date(s) received(ex:physical therapy, occupational therapy, speech therapy, recreation therapy, etc.)____

____
____
____
____

Problem Areas/Concerns:____

____
____
____
____

Unrelated Injuries:____

____
____
____
____

Allergies to both food and medication(s):____

____
____
____
____