

Confirmation of Health

Name: _____
Date: _____
Phone: _____

Membership Agreement

By signing this document, I acknowledge that I have voluntarily chosen to participate in a program of physical exercise. I acknowledge that I have been recommended to obtain a physicians examination and approval prior to beginning any exercise program, I acknowledge being informed of the strenuous nature of the training and assessment testing and the potential for unusual, but possible, physiological results including, but not limited to, abnormal blood pressure, fainting, heart attack, or death.

X _____

I understand and accept full responsibility for my use of all apparatus, facility privileges or services whatsoever, and will not hold harmless the trainer, its shareholders, directors, officers, employees, representatives, and agents from any and all negative loss, claim, injury, damage, or liability sustained or incurred.

X _____

YOU SHOULD NOT WORKOUT IF YOU HAVE THE FOLLOWING CONTRA-INDICATIONS: Check the box below:

You should never use Vacustep® if you have the following CONTRA-INDICATIONS:

	Yes	No
» PACEMAKER (DEFIBRILLATOR)	<input type="checkbox"/>	<input type="checkbox"/>
» THROMBOSIS OR INFECTION OF THE VEINS	<input type="checkbox"/>	<input type="checkbox"/>
» EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>
» BLOOD THINNERS	<input type="checkbox"/>	<input type="checkbox"/>
» BLOOD CLOT	<input type="checkbox"/>	<input type="checkbox"/>
» TUMORS	<input type="checkbox"/>	<input type="checkbox"/>
» VARICOSE VEINS	<input type="checkbox"/>	<input type="checkbox"/>
» STENT	<input type="checkbox"/>	<input type="checkbox"/>
» CARDIOVASCULAR DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
» PREVIOUS STROKE OR HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>
» PREGNANCY	<input type="checkbox"/>	<input type="checkbox"/>

You should get a Dr.'s permission to use the Vacustep® if you have the following CONTRA-INDICATIONS:

	Yes	No
» EXTREMELY LOW OR HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>
» SEVERE DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
» HEAVEY MENSTRUAL BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>
» DRUG ADDICTION	<input type="checkbox"/>	<input type="checkbox"/>
» RECENT WOUND FROM OPERATION OR SURGERY	<input type="checkbox"/>	<input type="checkbox"/>
» HIP OR KNEE IMPLANT	<input type="checkbox"/>	<input type="checkbox"/>
» RECENT INFECTION	<input type="checkbox"/>	<input type="checkbox"/>
» PREVIOUS OR CURRENT BACK PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
» STRONG ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>
» EATING DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>
» SEVERE MIGRAINE	<input type="checkbox"/>	<input type="checkbox"/>
» RECENTLY PLACED IUD'S, METAL PINS/PLATES	<input type="checkbox"/>	<input type="checkbox"/>

Weight cannot exceed 230 lbs under any circumstance. If you are over either weight limit, please notify a staff member to avoid damage to the machines.

If you are taking any medication that raises your heart rate, get a Dr.'s approval or exercise at your own risk.

I agree to the following and have none of these conditions. X _____

It is very important to drink plenty of water while using the VacuStep®.

As with all workouts, please get a Dr.'s permission before using the VacuStep® or any workout. If for any reason my health should change I will notify this facility immediately. X _____

I fully understand and agree to the terms of this agreement and obligations.

Print Name: _____ Rep: _____

Signature: _____ Date: _____