Senior Sign-up and Health Questionnaire

community health
northwest florida

Full name _____ DoB (mm/dd/yyyy) _____

Phone number _____ Email address _____

Address _____

Email address _____

Emergency contact information

Primary emergency contact

Name _____

Relationship _____

Phone number _____

Secondary emergency contact

Name _____

Relationship _____

Phone number _____

Health and medical information

Confidential — used only for safety during classes

Primary doctor _____ Phone _____

Hospital preference _____

Current medical conditions (check all that apply)

- ☐ High blood pressure
- ☐ Diabetes (Type 1/Type 2)
- ☐ Heart disease
- ☐ Arthritis
- ☐ Respiratory issues (asthma, COPD, etc.)
- ☐ Joint or mobility issues
- ☐ Balance/fall risk
- ☐ Other _____

Any current medications? _____

Any allergies? _____

Any restrictions or precautions from your doctor? _____

_____

Page 2

community health
northwest florida

Trackable wellness data

Use most recent data available; it can be updated as needed

Blood pressure ____ / ____ mmHg

Blood sugar (fasting) _____ mg/dL

Body-mass index _____

Cholesterol _____

A1C_____ %

Resting heart rate ____ BPM

Your goals for this program

Check all that apply

- ☐ Improve flexibility
- ☐ Increase strength
- ☐ Improve balance
- ☐ Reduce fall risk
- ☐ Manage stress
- ☐ Improve relaxation
- ☐ Improve blood pressure
- ☐ Improve blood sugar
- ☐ Social connection
- ☐ Other_____

Consent and acknowledgment

I understand that chair yoga is a form of physical activity and that I should consult with my healthcare provider before starting. I agree to participate at my own risk and will inform the instructor of any health changes.

Signature_____ Date _____

Waiver

I acknowledge and agree to indemnify, defend and hold harmless Community Health Northwest Florida, their officers, employees, agents and volunteers from all liability either individually or collectively that may result in any injury, illness or sickness to myself. I further agree to hold Community Health Northwest Florida from any liability, including payment of damages, costs and attorney fees. I will indemnify against any claims arising from or related to the negligence or contributory negligence of any employee or agent of Community Health Northwest Florida.

Signature_____ Date _____

Photo release

I do hereby grant authorization to Community Health Northwest Florida to use photographs or video of myself as a program participant for publicity promotional purposes.

Signature_____ Date _____