

## Medical History Form

### GENERAL INFORMATION

Parent's Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: [home]: \_\_\_\_\_ [work]: \_\_\_\_\_ E-mail: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ DOB: \_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ DOB: \_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ DOB: \_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ DOB: \_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_ Sex: \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ DOB: \_\_\_\_

1.	Has the child's doctor ever said they have any cardiovascular problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Do they frequently suffer from chest pains?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Have they ever had a heart attack?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Do they ever experience an irregular or racing heart rate during exercise or at rest?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Do they often feel faint or have spells of severe dizziness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Has a doctor ever said that their blood pressure is too high?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Do they often have difficulty breathing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Has a doctor ever told them that they have a bone or joint problem that might be aggravated with exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Is there a good physical reason not mentioned here why they should not follow an activity program even if they wanted to?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

The above mentioned information is true to the best of my knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

---

## Agreement and Release of Liability

Child's Name: \_\_\_\_\_  
\_\_\_\_\_

Parent's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

- 
1. In consideration of being allowed to participate in the activities and programs of Medical Fitness Pros' Katy Fit Kids Program and to use its facilities, equipment and machinery in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge and its directors, officers, agents, employees, representatives, successors and assigns, administrators, executors, and all others from any and all responsibilities or liability from injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above mentioned activities. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent acts or omissions of any of those mentioned or others acting on their behalf or any way arising out of or connected with my participation in any activities of Medical Fitness Pros' Katy Fit Kids Program or the use of any equipment of Medical Fitness Pros' Katy Fit Kids Program.
  2. I understand and am aware that strength, flexibility and aerobic exercise, including the use of equipment are a potentially hazardous activity. I also understand that fitness activities involve the risk of injury and even death, and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I understand this program does not provide any form of medical treatment, nor are its professionals, licensed medical practitioners. I hereby agree to expressly assume and accept any and all risks of injury or death.

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



## Program Expectations

We want to thank you for registering for the Medical Fitness Pros' Katy Fit Kids program! We are very excited about the program and having the opportunity to work with you kids. We plan to help the kids improve their strength, flexibility, stability, and motor skills. We definitely have a lot that we want to accomplish with your kids while we work with them. Our goal is to help as many kids improve their health and physical abilities as possible, but we want to hear from you as well. Please take a moment to let us know what we can do for you and your kids.

What expectations do you have for your kids that are enrolled in the Medical Fitness Pros' Katy Fit Kids Program? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What types of sports/activities do your kids have an interest in? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In order to reach out to more kids in the Katy Area, we'd like to know what groups you are involved with. If you have a phone number or e-mail address of someone we should contact, please let us know. Don't worry, we won't do anything to embarrass you 😊, but we would like to reach out to them to let them know more about our program.

What Home School Groups are you involved with?

- 1. \_\_\_\_\_ Contact Person: \_\_\_\_\_
- 2. \_\_\_\_\_ Contact Person: \_\_\_\_\_
- 3. \_\_\_\_\_ Contact Person: \_\_\_\_\_
- 4. \_\_\_\_\_ Contact Person: \_\_\_\_\_
- 5. \_\_\_\_\_ Contact Person: \_\_\_\_\_

Do you know other families that would benefit from this program? We would love for you to contact them to let them know about our program, but if you would prefer for us to contact them, please provide information below.

Name	Phone Number	E-Mail Address
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____



## Payment Information

This agreement is made on \_\_\_/\_\_\_/\_\_\_ between \_\_\_\_\_ whose primary address is \_\_\_\_\_ (Parent) and Medical Fitness Pros.

1. The start date of the Medical Fitness Pros' Katy Fit Kids program will be determined by mutual convenience.
2. Participant grants permission to Medical Fitness Pros to reproduce any photographs or video taken of participants for the purpose of publication, promotion, illustration, advertising, or trade, in any manner or in any medium.
3. The Participant must cancel this Agreement five business days prior to the start date of the next month. This agreement shall automatically renew on a monthly basis unless cancelled. To cancel this Agreement, e-mail or deliver a signed and dated notice which states that you, the Parent, are canceling the Agreement, or words of similar effect. Such notice shall be sent to: **MEDICAL FITNESS PROS** 21938 Royal Montreal Dr., Katy, TX 77450.

Please circle the appropriate program that you are enrolling in.

Number of Kids	Twice a Week	Three Times a Week
1	\$60	\$80
2	\$90	\$120
3	\$115	\$150
4	\$135	\$175
5	\$150	\$185

The participant will provide a valid credit card number. This card will be charged based on the program you are enrolling your kids in.

CC# \_\_\_\_\_ Exp \_\_\_\_\_

This Agreement contains the entire understanding of the parties and may not be amended without the specific written consent of both parties.

**IN WITNESS WHEREOF**, the parties have signed this Agreement on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_

\_\_\_\_\_

Jason Hodge  
Medical Fitness Pros

Parent