MCCCD Fitness Center

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Course** | **Section** | **Course End Date** | **Blood Pressure** | **BP Date** | **Instr. Initials** |
|  |  |  | / mm/Hg |  |  |
|  |  |  | / mm/Hg |  |  |
|  |  |  | / mm/Hg |  |  |
| Any change in medical condition requires a completion of a new Health Screening form. | | | | | |

Pre-participation Health Screening\*\*

The section immediately below will be completed by Fitness Center staff

PLEASE PRINT LEGIBLY

Last Name:       First Name:

Student ID#:

May be contacted via phone? Yes  No  If yes, Phone: (     )

May be contacted via email? Yes  No  If yes, Email address:

Emergency Contact:       Phone: (     )

**Please answer the following questions:**

**Yes** **No** Have you been participating in a planned physical activity program for at least 30 minutes at

a moderate intensity (feels somewhat hard) on at least 3 days of the week for at least the past 3 months?

**Yes** **No** Have you been told you have any of the following:

Cardiovascular disease (cardiac, peripheral artery, or cerebrovascular disease)

Metabolic disease (Type 1 or Type 2 diabetes)

Kidney disease

**Yes** **No** Do you have any signs or symptoms suggestive of cardiovascular, metabolic or renal disease?

Dizziness or fainting

Ankle swelling

Rapid heartbeat at rest

Chest pain or discomfort

Pain in legs with walking

Heart murmur

Unusual fatigue

Shortness of breath at rest or with mild activity

**Desired exercise intensity** (check):   Light Moderate Vigorous (breathing is deep and rapid)

**Yes** **No** Do you need a modified approach to exercise based on a current physical limitation?

Explain:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* Instructor Use Only \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*** | | | | | | | |
|  | Medical clearance not Necessary | | | | | | |
|  | Medical clearance not necessary for light to moderate intensity exercise only | | | | | | |
|  | Medical clearance recommended | | |  | Medical clearance required | | |
| Justification: | |  | | | | | |
|  | |  | | | | | |
| Instructor Name (print/sign): | | | / | | | Date: |  |
|  | | | | | | | |

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