FITNESS PROGRAM REGISTRATION FORM

(Please Print)

Name: _____ Date: _____

Gender: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Email: _____

OCU Affiliation: STUDENT / FACULTY / STAFF / ALUMNI / RETIREE / SPOUSE
(Circle One)

Emergency Contact: _____ Relationship_____

Phone Numbers for Contact: _____

Doctor: _____ Phone: _____

PROGRAM START DATE: _____

CLASS DAY(S)/TIME: _____

List any medical condition(s) that may limit/affect participation in program (please explain)

_____

_____

Prescription Medication currently taking/frequency _____

_____

Do you wear: glasses _____ and/or contact lenses _____

Complete Medical Release form also!