

FSU Campus Recreation Certification Registration and Consent Form

Participant's Name _____ Age _____ Sex M / F

Parent's Name (or Guardian if under 18 yrs.) _____

Address _____ City _____

State _____ Zip _____ Phone (H) _____ (W) _____

Class Name _____ Class Start Date _____ Class Time _____

Email Address _____

Please Check One:

Campus Rec Employee _____ FSU Student _____ FSU Faculty / Staff _____ Community _____

Please identify any condition that pertains to you.

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> High blood pressure
(140/90 or above) | <input type="checkbox"/> Smoker | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Chest pain and discomfort | <input type="checkbox"/> Neck Injuries | <input type="checkbox"/> Severe headaches |
| <input type="checkbox"/> Family history of heart disease | <input type="checkbox"/> Shoulder injuries | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Back injuries | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Hip Injuries | <input type="checkbox"/> Foot injuries | <input type="checkbox"/> Allergies to medication |
| | <input type="checkbox"/> Knee injuries | <input type="checkbox"/> Ankle injuries |

I, the parent or legal guardian of the above mentioned, do hereby permit him/her to participate in this program. I hereby release and discharge Florida State University Campus Recreation and all of its employees from any liability whatever to the undersigned from any matter arising out of injury or damage that may be sustained by the participation in this program.

I also hereby grant consent unto any medical doctor or hospital and authorize any aide, treatment, or care to said participant as, in the judgement of said doctor or hospital, may be required on an emergency basis, in the event said participation should be injured or stricken ill while involved in this program.

Please list any other conditions you believe should be brought to the attention of your instructor.

Please list any medications that you/your child take regularly.

I AM NOT WITHHOLDING ANY INFORMATION REGARDING MY/ CHILD'S HEALTH STATUS.

SIGNED _____ DATE _____

(Office Use Only)		
Date Paid _____	Amount _____	Receipt# _____
Check / Cash	Check# _____	Entered in computer Y / N