

Please take a few moments to fill out the information below **before** participating.

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

**Participant Information:**

**Name:** \_\_\_\_\_  
(First) (Last)

**Address:** \_\_\_\_\_  
(Street) (Apt. #)  
\_\_\_\_\_  
(City) (State) (Zip)

**Phone:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

**Gender:**  Male  Female **Date of Birth:** \_\_\_\_\_

**Do you have insurance/Medicaid/Medicare?**  Yes  No

**Do you have a regular doctor (primary care or internal)?**  Yes  No

**Would you like to receive any of the Coalition newsletters by email?**  Yes  No

**Please circle which Coalition programs you utilize:**

Bassett Family Practice	MedAssist	Ladies First	FAMIS Outreach
Health Education Classes	ACA Outreach	Eyes Forward	Health Coaching

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**Emergency Contact Information:**

**Name:** \_\_\_\_\_  
(First) (Last)

**Phone:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**What Coalition aerobics classes do you participate in? (Circle all that apply)**

Yoga Step Sculpt Instructor's Choice Tabata Water Aerobics Zumba Gold Chair Aerobics

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## HCI Family Aerobic Program Participant Agreement Form

By signing below you are agreeing to do the following:

- 1) Complete the Aerobics Participation Survey and update Emergency Contact Information with Instructor monthly,
- 2) Participate in aerobic workouts, unless otherwise directed by program and site staff,
- 3) Follow guidance from program and site staff during aerobics sessions,
- 4) Complete any other paperwork requested by program and site staff.

The MHC Coalition for Health and Wellness is grant funded largely through the Harvest Foundation and other local grant monies. This grant money enables us to provide free programming. To continue to do so, we require that you participate in all parts of our programs for desirable outcomes. This enables the program to continue growing throughout the community and to still be offered for free.

\* By signing this form you are also stating that you have medical clearance to participate and that you are releasing the MHC Coalition for Health and Wellness from any liability.

Your signature on this agreement form is required for you to participate.

***Thank you for your participation in our classes! Please ask about other Coalition programs!***

_____	_____	_____
<i>Printed Name</i>	<i>Signature or Guardian Signature</i>	<i>Date</i>

_____	_____	_____
<i>Printed Name</i>	<i>Signature or Guardian Signature</i>	<i>Date</i>

_____	_____	_____
<i>Printed Name</i>	<i>Signature or Guardian Signature</i>	<i>Date</i>

_____	_____	_____
<i>Printed Name</i>	<i>Signature or Guardian Signature</i>	<i>Date</i>