



The Medical Center

Community Walking Program Registration Form

Name _____ Date _____
(please print)

Mailing Address _____

City _____ State _____ Zip _____

Phone _____

Email Address (optional) _____

- Check here if you would like to receive periodic e-mail messages from The Medical Center pertaining to walking, fitness, and health. You may unsubscribe from this service whenever you choose.

Age Category (check one)

_____ Under age 10 _____ 20-30 _____ 55-70
_____ 10-14 _____ 31-39 _____ Over 70
_____ 15-19 _____ 40-54

Complete the following statement. In general, my overall health is . . .

_____ excellent _____ good _____ fair _____ poor

How many days a week do you currently walk 30 minutes or more?

_____ none _____ three days _____ six days
_____ one day _____ four days _____ seven days
_____ two days _____ five days

Release of Responsibility

I wish to participate voluntarily in The Medical Center Community Walking Program for the purpose of personal fitness. I understand that it is my personal responsibility to discuss my health status and exercise program with my physician. I hereby release The Medical Center from any liability for any medical event, injury, or accidental occurrence resulting from my participation in the Walking Program.

_____ (participant) _____ (date)

_____ (Parental signature required if under age 18.) _____ (date)