PRIMARY DAYS/TIME:
March 17th thru May 7th
Tuesdays & Thursdays
7:00 am to 7:40 am

LOCATION:
Wilson Area Intermediate
2400 Firmstone St,
Easton, PA 18042

FREE PROGRAMMING MEANT FOR ALL

BEFORE-SCHOOL YOUTH POWER, AGILITY, & SPEED TRAINING

COMPETITIVE EDGE - COMMITMENT - CAMARADERIE
- ENHANCE POWER, AGILITY, & SPEED
- INCREASE METABOLIC CONDITIONING MOBILITY
- INJURY RISK REDUCTION

OPEN TO STUDENTS IN 5TH THROUGH 8TH GRADE

TO REGISTER: Students MUST submit a signed health questionnaire and media release form to the school's main office by Friday, March 6th.

QUESTIONS: Contact St. Luke's Senior Director of Fitness & Sports Performance Mike Stgaard at Michael.Stgaard@sluhn.org.

REGISTER YOUR CHILD BEFORE FRIDAY, MARCH, 6TH.

JOIN THE FASTEST GROWING YOUTH SPORTS PERFORMANCE PROGRAMMING IN THE LEHIGH VALLEY. WE ARE ST. LUKE’S STRONG.
HEALTH & EXERCISE QUESTIONNAIRE

NAME ___________________________ D.O.B ____________
(First) (MI) (Last)

ADDRESS ___________________________ (City) ___________________________ (Zip)
(Street) ___________________________

PHONE ___________________________ GENDER _________ HEIGHT _________ WEIGHT ________

EMERGENCY CONTACT: NAME ___________________________ PHONE ___________________________

MD: ___________________________ PHONE ___________________________

PART 1 - HEALTH & MEDICAL HISTORY

YES  NO

1. _____ _____ Have you been seen by a physician for a **Cardiovascular** disease or disability (Myocardial Infarction, Coronary Artery Bypass Graft, Angina, Atrial Fibrillation, Pacemaker, Valvular Heart Disease, Chronic Heart Failure, Cardiac Transplant, Hypertension, Peripheral Artery Disease, Aneurysms)? Please explain:

2. _____ _____ Have you been seen by a physician for a **Pulmonary** disease or disability (Chronic Obstructive Pulmonary Disease, Chronic Restrictive Pulmonary Disease, Asthma, Cystic Fibrosis, Lung Transplantation)? Please explain:

3. _____ _____ Have you been seen by a physician for a **Metabolic** disease (Hyperlipidemia, End-Stage Metabolic Disease, Diabetes, Obesity, Frailty)? Please explain:

4. _____ _____ Have you been seen by a physician for an **Immunological or Hematological** disorder or disability (Cancer, Acquired Immune Deficiency Syndrome, Abdominal Organ Transplant, Chronic Fatigue Syndrome, Fibromyalgia, Anemia, Bleeding & Clotting Disorders)? Please explain:

5. _____ _____ Have you been seen by a physician for an **Orthopedic** disease or disability (Arthritis, Lower Back Pain, Syndrome, Osteoporosis, Lower Limb Amputation)? Please explain:

6. _____ _____ Have you been seen by a physician for a **Neuromuscular** disease or disability (Stroke, Spinal Cord Disability, Muscular Dystrophy, Epilepsy, Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Cerebral Palsy, Parkinson's Disease)? Please explain:

7. _____ _____ Have you been seen by a physician for a **Cognitive, Psychological or Sensory** disease or disability (Intellectual Disability, Alzheimer's Disease, Mental Illness, Stress & Anxiety Disorder, Hearing Impairment, Visual Impairment, Concussion)? Please explain:

8. _____ _____ Have you ever had any orthopedic injuries or surgical procedures? Please explain:

9. _____ _____ Do you often feel faint, dizzy or experience loss of balance? Please explain:

If you have any additional health conditions or concerns, please explain below.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Please list below any **Medications** or Vitamins/Supplements that you are currently taking.

__________________________________________________________

Do you have any **Allergies**? If so, please list below.

__________________________________________________________

**PART II - EXERCISE HISTORY & GOALS**

1. Are you currently involved in an exercise program? Yes____ No____
   
   If yes, what type of exercise and how often: ____________________________

2. What are your goals for your exercise program? _______________________

__________________________________________________________

**NAME:** ____________________________ **DATE:** ______________________

**SIGNATURE:** ____________________________ **WITNESS:** ______________________

**IF YOU ANSWERED YES TO ONE OR MORE OF THE QUESTIONS IN PART 1:**

It is highly recommended that you consult with your physician prior to beginning a fitness program. If you do not consult with a physician prior to initiating a fitness evaluation or program, you agree that you, your heirs, executors, administrators, assignees and personal representatives, release and forever discharge St. Luke’s University Health Network, and each of its subsidiaries and affiliates and their employees, agents, officers, directors and trustees, individually and collectively, from and against any liability, claims, damages, suits, fees, or expenses, including claims for death, personal injury and/or property loss, that you may have arising out of or resulting from your participation in a fitness program at St. Luke’s Fitness & Sports Performance Centers.

Signature: ______________________________________

**IF YOU ANSWERED NO TO ALL QUESTIONS IN PART 1:**

You can be reasonably sure that you can start a fitness program – begin slowly and progress gradually. Take part in a fitness assessment to determine your baseline fitness level and enable the St Luke’s Fitness & Sports Performance Staff to design and implement a personalized fitness program for you. Delay initiating a fitness program if: 1) you are not feeling well because of a temporary illness (cold, flu, fever, etc.), or 2) you have had a change in health status (ex. pregnancy, injury, health condition, etc.) – talk to your doctor before becoming more active.

**PLEASE NOTE:** If your health changes so that you then answer YES to any of the above questions, see a physician and notify us. It is recommended that you not continue your fitness program unless you complete this form again. I assume all risks of my involvement in a fitness program at St. Luke’s Fitness & Sports Performance Centers. I have read, understood, and completed this questionnaire accurately and honestly.

Signature: ______________________________________

**SLFSP Staff Use**

- Nutrition: □ Food Pyramid Reviewed
- Fitness Testing: □ Scheduled  □ Declined
- Fitness Program: □ Scheduled  □ Declined
ST. LUKE'S UNIVERSITY HEALTH NETWORK
MEDIA CONSENT AND RELEASE

1. Consent. I hereby consent to permit St. Luke’s University Health Network and its affiliates (the “Network”) and the Network’s designated media producer and editor (including any photographer and videographer) (the “Media”) to take photographs of me and interview me, and to make video and/or audio recordings of me (the “Material”).

2. Permission to Use and Disclose. I hereby consent to permit the Network (and the Media, on the Network’s behalf) to use and disclose the Material for any and all purposes relating to the promotion of the Network and its services, patient education, discussion of newsworthy topics, community reports, donor materials, or otherwise, whether appearing in any of the following “Displays”: newsletters, forums, advertising, publications, displays, written or audio media releases, digital media (including web pages, online advertising and forums, and social media), or other formats.

3. Withdrawal of Consent. I understand that I can ask that any photography, interview, or recording be stopped at any time, and that if I make such a request, my consent will be considered withdrawn. I may withdraw my consent after the Material has been produced, by sending a letter to St. Luke’s University Health Network, 801 Ostrum Street, Bethlehem, PA 18015, Attention: Director, Marketing and Public Relations. Once my consent is withdrawn, the Network may no longer use or disclose my Material for the purposes listed in this consent. However, if the Network relied on my consent before it was revoked to create and disclose the Material, the Network may continue to use and disclose those Materials even after my consent has been revoked.

4. No Approval Required. I understand that I have no right to inspect or approve the Displays in which my Material, or any part of my Material, may be used. However, I understand that the Network and the Media will use the Material in good taste.

5. No Compensation. I understand that the Material will be the property of the Network or the Media. I waive any and all rights I may have in the Material. I understand and agree that I will not receive any compensation in any form from the Network or the Media, or from any other source as a result of my consent to have the Material taken, used, disclosed, or distributed.

6. Release. I irrevocably release the Network, its employees and agents, and the Media from any and all liability arising from or connected with the taking, use, disclosure and distribution by the Network or the Media of the Material.

Adult Acknowledgement. I understand the terms and meaning of this Consent and Release. I certify that I am 18 years of age or older.

Print Name: ___________________________ Date: ___________________________

Signature ___________________________

Parent/Guardian Acknowledgement. I certify that I am the parent or legal guardian of the below named minor child and I understand the terms and meaning of this Consent and Release.

Print Name of Minor Child: ___________________________

Print Name of Parent/Legal Guardian: ___________________________

Signature of Parent/Legal Guardian ___________________________ Date: ___________________________

CONTACT PHONE NUMBER: ___________________________

CONTACT EMAIL ADDRESS: ___________________________
**Power of Attorney Acknowledgement.** I certify that I have the authority to execute this Consent and Release for the person named below as his/her Agent under a Power of Attorney granted to be by the person named below, and I understand the terms and meaning of this Consent and Release.

Print Name of Grantor: ____________________________

Print Name of Agent: ____________________________

__________________________________________
Signature of Agent
Date: ____________________________

CONTACT PHONE NUMBER: ____________________________
CONTACT EMAIL ADDRESS: ____________________________