

**COMANCHE NATION FITNESS CENTER  
YOUTH (Under 18 yo.) MEMBERSHIP APPLICATION**

NAME \_\_\_\_\_ DOB \_\_\_\_\_ GENDER \_\_\_\_\_

ADDRESS (Street/P.O.) \_\_\_\_\_ PHONE \_\_\_\_\_

(City, ST, Zip) \_\_\_\_\_ CELL \_\_\_\_\_

EMERGENCY CONTACT (MUST HAVE) \_\_\_\_\_ RELATION \_\_\_\_\_

(NAME) \_\_\_\_\_

(PHONE) \_\_\_\_\_

TRIBAL AFFILIATION & ROLL NUMBER \_\_\_\_\_ CNFC MEMBER # \_\_\_\_\_

**TERMS & CONDITIONS**

Comanche Nation Fitness Center and Comanche Nation of Oklahoma are not responsible for any personal belongings left at this facility.

Any items left will be held for one week and then given to local charities.

Locker space is available for day use only and is limited to a first come first serve basis.

Locks are not provided. Any locks left will be removed at members expense.

Children under the age of 12 years will not be allowed access to weight room or equipment.

Applicants must show a Certified Degree of Indian Blood Card or valid state/government/school identification.

Appropriate footwear (athletic shoes) must be worn at all times unless in aerobic/mat area.

Disorderly conduct will result in permanent ban from facility.

**WE RESERVE THE RIGHT TO REFUSE SERVICE TO ANYONE.**

I have read, understand and signed an Informed Consent Waiver. \_\_\_\_\_  
(Initial)

By signing below I agree to the above terms and conditions.

\_\_\_\_\_  
Applicant Signature Date

Staff Initial \_\_\_\_\_ Date Rec'd \_\_\_\_\_

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Member # \_\_\_\_\_

*INFORMED CONSENT WAIVER*

The undersigned hereby gives informed consent to engage in participating in a variety of activities. All exercise and physical activity sessions will be supervised and monitored by a trained exercise technician or a member of the fitness center staff.

These activities may include but are not limited to walking, jogging, running, weight training and callisthenic exercises performed within fitness center or with fitness center staff.

There exists a possibility that certain detrimental physiological changes may occur during exercise and/or exercise testing. These changes could include muscle soreness, heat-related illness, abnormal blood pressure, and in rare instances, a heart attack. If abnormal changes occur, the staff has been trained to recognize symptoms and take appropriate actions including administering CPR and First Aid.

I have read this form and understand that there are inherent risks associated with any physical activity. I also recognize that my workout is voluntary and I hereby absolve the Comanche Nation, the Comanche Nation Fitness Center, and/or staff of the Comanche Nation Fitness Center and release them from any and all responsibility in the event of an injury or health-related illness.

I further recognize that any medical care that I may require is my personal/financial responsibility.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Printed Name of Parent or Guardian

Staff Initial \_\_\_\_\_ Date Rec'd \_\_\_\_\_

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HEALTH HISTORY

Past and Present Personal Health History (check ALL that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Diseases of the heart and arteries | <input type="checkbox"/> Abnormal ECG or EKG             |
| <input type="checkbox"/> High Blood Pressure (hypertension) | <input type="checkbox"/> Angina Pectoris (chest pain)    |
| <input type="checkbox"/> Epilepsy                           | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Anemia                             | <input type="checkbox"/> Abnormal chest X-Ray            |
| <input type="checkbox"/> Cancer                             | <input type="checkbox"/> Asthma                          |
| <input type="checkbox"/> Other Lung Diseases                | <input type="checkbox"/> Orthopedic or muscular problems |
| <input type="checkbox"/> Diabetes                           |  |

If any of the above are checked, please explain further and indicate any recommendations your doctor has made regarding exercise.

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Level of physical activity (please circle)

- YES      NO      Are you currently involved in a regular aerobic exercise program such as walking, jogging, cycling, swimming, step aerobics, etc.?
- YES      NO      Are you currently participating in weight training?
- YES      NO      Do you perform stretching exercises on a regular basis?

What best describes your level of physical activity during the past 4-6 weeks? (Check one)

- Active (More than 3 miles of fast pace walking plus light physical activity daily)
- Moderately Active (Less than 3 miles of walking plus light physical activity daily)
- Occasionally Active (Only light physical daily)
- Inactive (Minimal physical activity/no increase in heart rate)

Please indicate any additional exercise information which you think is important for us to know prior to fitness testing or exercise.

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Is there a family history of heart disease, hypertension (high blood pressure), stroke, diabetes, heart failure, lung disease or epilepsy?       YES       NO

If YES, please provide information regarding who the relative is, the medical problem and the age at onset or death:

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- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Do you currently smoke cigarettes? How many?                       |
|                              |                             | If you smoked in the past, when did you quit?                      |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Are you currently taking medications prescribed by a doctor?       |
|                              |                             | If YES, indicate name of medication, dosage and reason for taking: |
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Please indicate any additional medical information you think is important for us to know prior to fitness testing or exercise. Please note any NON-prescribed medications currently taking.

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