



MARRA/UMass Lowell Boathouse Membership Application

	<i>3 Months</i>	<i>6 Months</i>	<i>1 year</i>
<input type="checkbox"/> MARRA/Boathouse Membership	X	X	\$350
<input type="checkbox"/> Recreation Center Membership	\$100	\$180	\$300

Name: _____

Address: _____ E-Mail _____

City: _____ State: _____ Zip Code: _____

Phone #: _____

Informed Consent: I understand that the use of University of Massachusetts Lowell recreational facilities is purely voluntary and that neither the Office of Campus Recreation, the Department of Athletics nor the University of Massachusetts Lowell assumes any responsibility for any injury incurred through this use. I agree to indemnify and hold harmless the Commonwealth, the University, its Trustees, officers, agents and employees from and against any and all claims, liability, losses, third party claims, damages, costs, or expenses (including attorneys' fees) arising out of or resulting from my, use of the University's recreational facilities. I have read and will abide by established policies for facility use.

Signature: _____ Date: _____

Office Use:

Date of Purchase: _____ Amount: _____ Staff Initials _____

Term: 3 months _____ 6months _____ 1 Year _____ EXPIRES: _____

Payment Method: ___ Check (payable to UMass Lowell Campus Recreation)
 ___ Credit Card: Visa MasterCard Discover
 ___ Cash

Renewal Date _____ Expires _____

Renewal Date _____ Expires _____

Renewal Date _____ Expires _____

***** Important: When renewing please review CRC Health History Questionnaire and let us know of any changes.**

UMASS Lowell CRC Health History Questionnaire

Name: _____

Date: _____

Emergency Contact: _____

Phone: _____

Chart A. To the best of your knowledge, do you have any of the following? Please check all that apply.

<input type="checkbox"/> history of heart disease or heart attack	<input type="checkbox"/> heart trouble or transplant	<input type="checkbox"/> vascular disease
<input type="checkbox"/> bypass or angioplasty	<input type="checkbox"/> chronic obstructive pulmonary disease	<input type="checkbox"/> emphysema
<input type="checkbox"/> asthma	<input type="checkbox"/> diabetes	<input type="checkbox"/> epilepsy
<input type="checkbox"/> bronchitis	<input type="checkbox"/> stroke	<input type="checkbox"/> currently pregnant
<input type="checkbox"/> known heart murmur	<input type="checkbox"/> shortness of breath at rest/mild exertion	<input type="checkbox"/> dizziness or fainting
<input type="checkbox"/> heart palpitations	<input type="checkbox"/> claudication	<input type="checkbox"/> rapid heart beat
<input type="checkbox"/> shortness of breath when lying flat or in bed <input type="checkbox"/> pain or discomfort in chest or surrounding area		

Chart B. ACSM risk factors for coronary heart disease: Please check all that apply.

<input type="checkbox"/> Age: Are you male and over the age of 45 OR female and over the age of 55?
<input type="checkbox"/> Family History: Is there a history of heart attack, coronary revascularization, or sudden death in your immediate relative males (father, brother, son) before age 55 or females (mother, sister daughter) before age 65?
<input type="checkbox"/> Hypertension: Has your systolic blood pressure been greater than or equal to 140 mmHg or has your diastolic blood pressure been greater than or equal to 90mmHg on at least two separate occasions?
<input type="checkbox"/> Impaired fasting glucose: Have you had fasting blood glucose of greater than or equal to 110mg/dL on at least two separate occasions?
<input type="checkbox"/> Obesity: Do you have a BMI (Body Mass Index) of 30kg/m ² or more, or a waist girth of greater than 39.4 inches (100cm)? <i>See chart for BMI.</i>
<input type="checkbox"/> Hypercholesteremia: Is your total blood cholesterol greater than 200mg/dL, or you LDL greater than 130 mg/dL, or is your HDL below 35 mg/dL, or are you on lipid lowering medication?
<input type="checkbox"/> Sedentary Lifestyle: Are you currently inactive, i.e. no regular exercise or recreation, and have a sedentary job?
<input type="checkbox"/> Cigarette Smoker: Are you a current smoker, or have you quit within the previous 6 months?

I have read, understood, and completed this questionnaire. I understand that this questionnaire is used solely for screening purposes to help determine my readiness to participate in physical activity or fitness assessment and that it is not to replace professional medical advice or evaluation.

Signature: _____

Date: _____

Witness: _____

Date: _____

If you answered checked off 1 or more conditions in Chart A OR 3 or more conditions in Chart B, written physician approval is required prior to your use of the Campus Recreation Center or participation in our programs. If this is the case, please complete the Medical Information Release form below.

MEDICAL INFORMATION RELEASE

Please provide the following information to expedite the physician approval process. I hereby give my physician permission to release any pertinent medical information from my medical records to the University of Massachusetts at Lowell. I understand that this information will be kept confidential. I am aware that this release will expire within one year of signature & that I may revoke my medical release at any time.

Participant's Signature: _____

Date of Birth: _____

Today's Date: _____

Name of Physician

Address

Phone & Fax Numbers
(phone): _____

(fax): _____