Print Form

Hui Ho'ola Maika'i Program

INDIVIDUAL CLIENT REGISTRATION FORM

Ho`ola Lahui Hawai`i
Kaua`i Community Health Center

CLIENT INFORMATION

LAST NAME: | FIRST NAME: | MIDDLE INITIAL: | MAIDEN NAME:

MAILING ADDRESS: | CITY: | STATE: | ZIP CODE:

HOME PHONE: | WORK PHONE: | OTHER PHONE:

DATE OF BIRTH: | ☐ FEMALE | ☐ MALE | E-mail

RACE: (SELECT ONLY ONE) | PLEASE LIST IF YOU SELECTED OTHER:

ETHNICITY: (SELECT ONLY ONE)

PRIMARY LANGUAGE: ☐ English ☐ Hawaiian ☐ Other | Marital Status (Select One)

Homeless: | IF HOMELESS - INDICATE DATES: FROM: | TO:

FAMILY INCOME (YEARLY): | FAMILY SIZE:

EMERGENCY CONTACT INFORMATION

(List person we may contact in case of emergency (If possible, someone from outside the home)

NAME: | RELATIONSHIP: | PHONE:

PARENT/GUARDIAN INFORMATION

(COMPLETE THIS SECTION ONLY IF CLIENT IS UNDER 18 YEARS OLD)

RELATIONSHIP TO CLIENT: ☐ PARENT ☐ GUARDIAN

Last Name: | First Name | E-Mail Address

Mailing Address: | City: | State: | Zip Code:

Residence Address: | City: | State: | Zip Code:

Home Phone: | Cell Phone: | Date of Birth:

Employer | Work Phone:

How did you hear about us: (Check all that apply)

☐ Friend ☐ Flyer ☐ Community Event ☐ Other | Please explain Other:

☐ Radio ☐ Newspaper | Which Community Event?

Health Information

List Medications you are currently taking:

Physician's Name: | Physician's Phone Number

Does your Physician know that you are participating in a fitness class? ◯ YES ◯ NO

Do you now or have you had within the past year:			**If Yes, Please Explain:**
1. History of heart problems?	◯ YES	◯ NO	
2. Recent Surgery in the past 6 months?	◯ YES	◯ NO	
3. Advised by Physician not to exercise?	◯ YES	◯ NO	
4. High blood pressure?	◯ YES	◯ NO	
5. History of lung problems?	◯ YES	◯ NO	
6. Muscle, joint or back disorder that could be aggravated by physical activity?	◯ YES	◯ NO	
7. Difficulty with physical exercise?	◯ YES	◯ NO	
8. Have you been told you have diabetes?	◯ YES	◯ NO	
9. Have you been told you have high cholesterol?	◯ YES	◯ NO	
10. History of heart problem in immediate family?	◯ YES	◯ NO	
11. Problems with obesity?	◯ YES	◯ NO	
12. Do you have any allergies?	◯ YES	◯ NO	

What physical activity do you presently do?

Best way to reach you: ☐ Cell: _____ ☐ Text _____ ☐ Email: _____

Waiver and Consent Agreement

I consent to participate voluntarily in Ho'ola Lahui Hawai'i's Programs. I am aware that this program includes health screenings which include but is not limited to monitoring of blood pressure, weight, body fat and body mass index. I understand that by signing this form, I agree for myself, my heirs, executors and administrators to release, indemnify and hold harmless all Ho'ola Lahui Hawaii committee members, its affiliates, officers, directors, employees, volunteers and all sponsoring businesses and organizations and their agents and employees from any and all activities, whether it results from negligence of any of the above or from any other cause. I further agree that this consent and waiver agreement shall be applicable to any owner of a facility and/or property at or upon which the program is held. I am solely responsible for my own health and safety. I represent that I am physically fit and able to participate in this program. I am hereby, advised to consult my physician before participating in this program. Consultation with a physician my be required. Furthermore, I hereby grant full permission to any and all of the foregoing to use my name, my voice and or my picture or likeness in any broadcast, telecast, advertising, promotion or other account of this event for any purposes whatsoever. I understand that there will be a $20.00 service charge for all returned checks. I have read, understand and agree to the terms of this agreement and have, of my own free will, signed below to indicate so.

Signature of Client **(OR)**
(Parent/Guardian Signature for Client if UNDER 18 years old) _____

PRINT NAME : _____ Date: _____

HUI HO'OLA MAIKA'I STAFF ONLY:

Reviewed By: | Date: | ☐ New | ☐ Updated

MEDICAL CLEARANCE (MC): ☐ YES ☐ NO

IF YES: ☐ Gave MC to Client ☐ Faxed MC to Doctor listed below

Date Medical Clearance Received

Date Medical Clearance Received Noted on Registrant Card

Doctor:

Date Faxed:

☐ Medical Clearance Filed In Client Chart