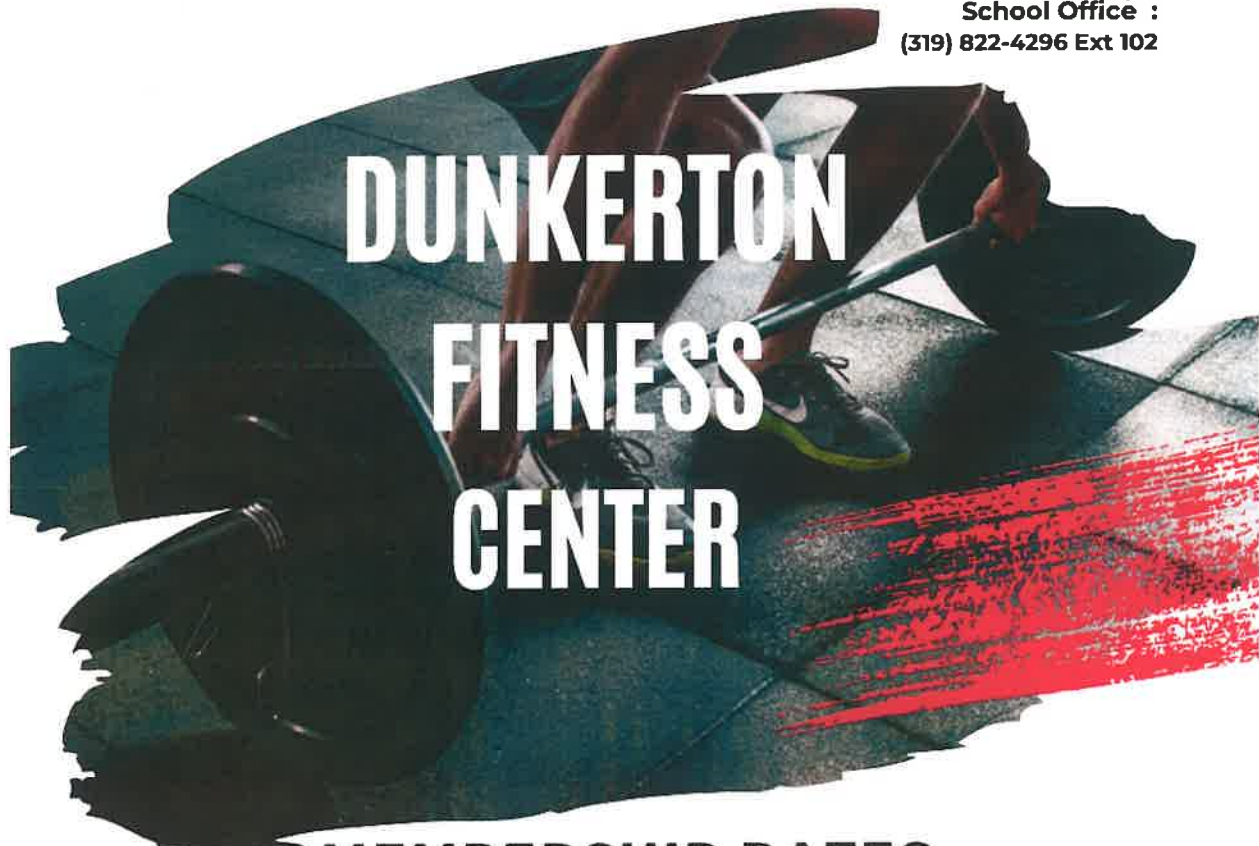


Call the High  
School Office :  
(319) 822-4296 Ext 102



# DUNKERTON FITNESS CENTER

## MEMBERSHIP RATES:



### Senior Membership

Age 60+  
\$60.00 annually

Age 60+ Out of District  
\$ 120.00 annually



### Adult Membership

Age 13+  
\$ 85.00 annually

Age 13+ Out of District  
\$ 210.00 annually



### Family Plan

\$ 160.00 annually

\$ 320.00 annually  
Out of District

**START  
TODAY!**

To begin your membership please complete the following steps:

1. Read through documents and complete
  - a. Physical Health Status Questionnaire
    - i. Your physician will need to sign the bottom portion of this page and fax a statement clearing you for workout.
  - b. Read and sign the Permission and Waiver Form
  - c. If a participant is under the age of 18 they will need to sign a participation agreement and release form with their guardian
2. Upon filling out the paperwork you may fax all documents to the HS at (319) 822-9456, or return to the completed paperwork to the High School Office.
3. Cash or check is accepted and a key fob will be provided upon completion of your membership.
4. Lost key fobs \$5.00 or for any additional key fobs.
5. If you have the original black key fob this can be reactivated instead.

**The Dunkerton Fitness Center is open to the public. It is open 24 hours a day, seven days a week. Restrooms are located further down the hallway. Please be courteous to other members and wipe down machines after use. If you have any questions please call the High School Office at (319) 822-4296, Ext 102.**



# Dunkerton Fitness Center

## Physical Health Status Questionnaire

509 S. Canfield St. • Dunkerton, Iowa, 50626 • (319) 822-4296  
www.dunkerton.k12.ia.us

Superintendent: Dan Fox  
Board President: Kirby Marquart

High School Principal: Kory Kelchen  
Fitness Center Clerk: Joni Wheeler

Business Mgr: Kelly Zahrt

Participant's Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

Who to Contact in Case of Emergency: \_\_\_\_\_

City: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Primary Care Physician Address \_\_\_\_\_

Email Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Every potential participant in the Fitness Center Program is required to fill out this questionnaire prior to participation. This form is designed to help potential participants determine if physical activity may be inappropriate for them, or if such activity should be restricted. **The District, the School and their employees, shall have no responsibility for preventing participation and no liability for allowing participation based on the information provided in this questionnaire or otherwise.** All potential participants should consult with a physician before participating. Please fill out the questionnaire carefully.

	Yes	No
1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?	_____	_____
2. Do you feel pain in your chest when you do physical activity?	_____	_____
3. In the past month, have you had chest pain when you were not doing physical activity?	_____	_____
4. Do you lose your balance because of dizziness or do you ever lose consciousness?	_____	_____
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?	_____	_____
6. Is your doctor currently prescribing drugs for your blood pressure or heart condition?	_____	_____
7. Do you know of any other reason why you should not do physical exercise?	_____	_____

**NOTE: If you answered Yes to any of the above questions, please see your physician before continuing with this program.**  
Additional questions: Risk For Cardiovascular Diseases.

9. Does your family have a history of heart disease?	_____	_____
10. Are you currently a smoker (tobacco smoking on or more times per week)?	_____	_____
11. Do you have high blood pressure reported by a physician after repeated measurements?	_____	_____
12. Do you have a high cholesterol level reported by a physician?	_____	_____
13. To your knowledge is there any other reason not stated here why you should not participate in physical activity program? IF yes, please explain.	_____	_____
14. Are you currently taking any medications? If so, please list them and explain why you are taking them.	_____	_____

Signature of Participant \_\_\_\_\_

Date \_\_\_\_\_

Signature of Primary Care Physician \_\_\_\_\_

Date \_\_\_\_\_



# Dunkerton Fitness Center

## Permission and Waiver Form

509 S. Canfield St. • Dunkerton, Iowa, 50626 • (319) 822-4295  
 www.dunkerton.k12.ia.us

Superintendent: Dan Fox  
 Board President: Kirby Marquart

High School Principal: Kory Kelchen  
 Fitness Center Clerk: Joni Wheeler

Business Mgr: Kelly Zahrt

### PERMISSION AND RELEASE

The facilities, equipment and activity programs offered by the Dunkerton Community School District (hereinafter "Program") have been designed and established to provide the optimum level of beneficial exercise and enjoyment without compromising the health and safety of those who utilize the facilities or participate in the activities. Because of the nature of the program made available in the Program which is integral part of many of the activities, there is inherent risk of injury which characterizes any exercise activity resulting in a practical limitation placed on the Program in its efforts to prevent injuries to participants, whether actively participating in exercises, utilizing the equipment, or taking advantage of the various other activities in the Program. This Program enlists your assistance in assuring that the Program is utilized in a proper manner so that the inherent risks which exist under the control of the Program, as well as those outside the control of the Program, and participate within the control of each individual participant are minimized by the participant's thoughtful and cautious use of the Program. In consideration of these factors, the undersigned participant acknowledges the existence of risks in connection with these activities, assumes such risks, and agrees to accept the responsibility for an injuries sustained to him/her in the course of his/her use of the Program. The participant further acknowledges the existence of and the need for certain rules and procedures concerning the use of the Program. He/she agrees to abide by those rules and to make every individual effort to assure that the Program is kept in a safe and usable condition. Having read the preceding, the participant acknowledges his/her understanding of those risks set forth herein and knowingly agrees to accept full responsibility for his/her own exposure to such risks. I, the undersigned, desire to participate in the Program. By signing this document, I acknowledge that I understand and agree to the following terms and conditions:

1. I represent to the Program that to the best of my knowledge, I am physically capable of participating in exercise programs and that I have consulted my personal physician.
2. I recognize that risk of illness and injury are inherent in any exercise program and I am participating in this Program upon the express agreement and understanding that I do hereby for myself, my heirs, executors, administrators and assigns, waive and release from any and all claims, costs, damages, liabilities, expenses or judgments, including attorney fees and court costs, arising out of my participation in the program or any illness or injury resulting therefrom.
3. I agree to inform the Program before participation in any of its activities of any change in my physical condition which might in any way adversely affect my ability to safely participate in the program.
4. I am executing this permission and waiver form to permit me to participate in the Program.
5. Upon request I shall furnish the Program the name of my physician, and by these presence, I hereby grant authority to my physician to divulge any and all information concerning my physical condition which the Program may be required in order to make a judgement as to whether or not I am physically qualified to participate in such program. A photocopy of this Waiver and Release, given to my physician, shall act in the same manner as an originally signed authority.

Any and all information obtained through this or any other document with reference to this Program is strictly protected under the Privacy Protection Act (PPA), the Family Educational Rights and Privacy Act (FERIA), and the Children's Online Privacy Protection Act (COPRA).

Participant's Signature \_\_\_\_\_

Date \_\_\_\_\_

Legal Guardian Signature (if applicable) \_\_\_\_\_

Date \_\_\_\_\_