MEDICAL STATEMENT

Participant Record (Confidential Information)

This is a statement in which you are informed of some potential risks involved in participating in the physical activities and exercise programs conducted by Luminaries Retreat, LLC, and of the conduct required of you during the wellness programs. Your signature on this statement is required for you to participate in any and all wellness and training programs offered.

Read this statement prior to signing it. You must complete this Medical Statement, which includes the medical questionnaire section. If you are a minor, you must have this Statement signed by a parent or guardian. Exercise programs and other physical activities can be demanding, but when performed correctly, applying correct techniques, they can be relatively safe. When established safety procedures are not followed, however, there are increased risks.

A person with coronary artery disease, uncontrolled epilepsy, a severe medical problem or who is under the influence of alcohol or drugs or is pregnant, should not participate in any vigorous activities. If you have asthma, heart disease, other chronic medical conditions or you are taking medications on a regular basis, you should consult your doctor and the instructor before participating in this program, and on a regular basis thereafter upon completion. If you have any additional questions regarding this Medical Statement or the Medical Questionnaire section, review them with your instructor before signing.

The purpose of this Medical Questionnaire is to find out if you should be examined by your doctor before participating in any programs or activities provided by Luminaries, Retreat, LLC. A positive response to a question does not necessarily disqualify you from participating in our wellness activities. A positive response means that there is a preexisting condition that may affect your safety while participating and you should seek the advice of your physician prior to engaging in certain activities.

_____ Are you pregnant, or are you attempting to become pregnant?

_____ Are you presently taking prescription medications? (with the exception of birth control)

_____ Can you answer YES to one or more of the following? (If YES, circle which conditions)

- currently receiving medical care
- currently smoke a pipe, cigars or cigarettes
- have a high cholesterol level
- have a family history of heart attack or stroke
- have high blood pressure
- have T1 or T2 diabetes

Have you ever had or do you currently have…

_____ Asthma, or wheezing with breathing, or wheezing with exercise?

_____ Frequent or severe attacks of hay fever or allergy?

_____ Frequent colds, sinusitis or bronchitis?

_____ Any form of lung disease?

_____ Pneumothorax (collapsed lung)?

_____ Other chest disease or chest surgery?

_____ Behavioral health, mental or psychological problems (Panic attack, fear of closed or open spaces)?

_____ Epilepsy, seizures, convulsions or take medications to prevent them?

_____ Recurring complicated migraine headaches or take medications to prevent them?

_____ Blackouts or fainting (full/partial loss of consciousness)?

_____ Frequent or severe suffering from motion sickness (seasick, carsick, etc.)?

Please answer the following questions on your past or present medical history with a YES or NO. If you are not sure, answer YES. If any of these items apply to you, we must request that you consult with a physician prior to participating in any program or event.

_____ Any recent accidents or surgeries?

_____ Inability to perform moderate exercise (example: walk one (1) mile within 20 minutes)?

_____ Head injury with loss of consciousness in the past five years?

_____ Recurrent back problems or back surgery?

_____ Back, arm or leg problems following surgery, injury or fracture?

_____ High blood pressure or take medicine to control blood pressure?

_____ Heart disease or heart attack?

_____ Angina, heart surgery or blood vessel surgery?

_____ Sinus surgery?

_____ Muscle group strain or sprain (such as pulled hamstring or shoulder injury)?

_____ Ear disease or surgery, hearing loss or problems with balance?

_____ Bleeding or other blood disorders?

_____ Hernia?

_____ Ulcers or ulcer surgery?

_____ A colostomy or ileostomy?

_____ Recreational drug use or treatment for, or alcoholism in the past five years?

The information I have provided about my medical history is accurate to the best of my knowledge.

Biometric Data:

Current Weight (approximate is fine if unknown): _____ Height: _____

Brief Description of Weight Loss/Gain History if relevant to your goal-setting at Luminaries Retreat:

LUMINARIES RETREAT, LLC

***I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition*.**

_____ _____

Signature of Participant **Date**

Please print legibly.

Full Name_____

Date of Birth _____ Age _____

Mailing Address _____

City_____ State_____ Zip Code _____

Home Phone ( )_____ Business Phone ( )_____

Email _____

Name and address of your personal/ family Physician

Physician _____ Clinic/Hospital _____

Address_____