Membership Registration

(PLEASE PRINT CLEARLY)

Name: _____ **Date:** _____
Gender (M/F): _____ **Age:** _____ **DOB:** _____
Address: _____ **Phone#:** _____
Email: _____

Participant Status: STUDENT / FACULTY / STAFF / SPOUSE / OTHER
(Circle One)

Emergency Contact Name: _____ **Relationship:** _____

Phone # for Emergency contact: _____

Emergency Contact Email: _____

Primary Care Physician
Doctor's Name: _____ **Phone:** _____
NOTE: The following health history will assist your personal trainer in creating an exercise program most appropriate for your needs. Please answer honestly and be aware that all information will be kept confidential.

<u>QUESTIONS:</u> YES / NO
(*Please circle Yes or 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? YES / NO

2. Do you feel pain in your chest when you do physical activity? YES / NO

3. In the past month, have you ever had chest pain when you were not doing physical activity? YES / NO

4. Do you lose balance because of dizziness or do you ever lose consciousness? YES / NO

5. Do you have a bone or joint problem that could be made worse by a change in your physical activity? YES / NO

6. Is your doctor currently prescribing medication for high blood pressure or a heart condition? YES / NO

7. Do you currently smoke? YES / NO

8. Do you have diabetes? If so, type I or type II? YES / NO

Assigned Trainer *(FOUO)* _____

9. Has a physician ever told you or are you aware that you have high blood pressure ? YES / NO

10. Have you had surgery in the past year? YES / NO
If yes, please explain.

11. Are you currently taking any prescription medications or beta blockers? YES / NO
If yes, please list each and the reason for taking it: Medication(s) Reason for taking it

_____
_____
_____

12. Do you have emphysema, asthma, or any other lung disease? YES / NO
If yes, please specify:

13. Has a physician ever told you or are you aware that you have a high cholesterol level? YES / NO

14. Have you ever experienced a stroke or a heart attack? YES / NO
If yes, explain and give date of occurrence:

15. Has anyone in your immediate family (parents/brothers/sisters/) had a heart attack, stroke, or cardiovascular disease before the age of 55? YES / NO

16. Are you pregnant or trying to become pregnant? YES / NO

17. Known Allergies (food, drug, insects, etc.) Please list if any: YES / NO

18. Are you aware, through your own experience or the advice of a doctor, of any reason why you should consult with a doctor prior to beginning a new exercise program? YES / NO

19. How did you hear about us? Circle One: Internet_____ TV_____
Newspaper_____ Friend_____ Advertisement_____

MEDICAL RELEASE FOR TREATMENT

I authorize COPS AND KIDS LONG ISLAND and Starrett City Boxing Club, Inc. & employees of COPS AND KIDS LONG ISLAND and Starrett City Boxing Club, Inc., Inc. to authorize on my behalf all appropriate medical treatment which may be required in the event of illness or injury to me resulting in any manner from participating in a COPS AND KIDS LONG ISLAND and Starrett City Boxing Club, Inc. Starrett City sponsored activity.

_____
Date / Participant's Signature

_____ _____
Date / Parent or Guardian (If participant is a minor) Signature

PERSONAL TRAINING GUIDELINES

Promptness: It is very important that the member arrives on time for each scheduled appointment with a trainer. Tardiness will result in the normal length of the workout being shortened since the scheduled end of the session may be fixed due to schedule constraints of the trainer. I have read, understood, and agree to the above guidelines.

_____

Date / Participant's Signature

_____ _____

Date / Parent or Guardian (If participant is a minor) Signature

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I understand that participation in this program is on a voluntary basis, and acknowledge that neither COPS AND KIDS LONG ISLAND will accept responsibility for injuries sustained while participating in an exercise program supervised by a personal trainer. Every participant is strongly encouraged to carry his/her own insurance for any unforeseen accident(s). I, the participant (parent or guardian if a minor), have read and understand this statement and agree to notify the COPS AND KIDS LONG ISLAND Starrett City Boxing Club if there is any change in my health during my participation in the program. Any information I have provided on this form is true, correct and complete to the best of my knowledge.

RELEASE OF LIABILITY

I understand that parts of COPS AND KIDS LONG ISLAND and Starrett City Boxing Club, Inc. activities may be physically demanding. I recognize the inherent risk of injury in COPS AND KIDS LONG ISLAND and Starrett City Boxing Club, Inc. I understand that each participant must assume the risk of injury and any related financial responsibility that could result from participation in any COPS AND KIDS LONG ISLAND and Starrett City Boxing Club, Inc. activity. I agree to hold harmless COPS AND KIDS LONG ISLAND and Starrett City Boxing Club, Inc., its employees, staff, agents and volunteers from all claims, including bodily injury, that I may have on my behalf that may be sustained in connection with my participation in these physically demanding activities.

_____

Date / Participant's Signature

_____ _____

Date / Parent or Guardian (If participant is a minor) Signature

COPS AND KIDS LONG ISLAND

RULES & REGULATIONS

EFFECTIVE – November 1, 2010

1. NEW MEBMERSHIP FEES WILL BECOME EFFECTIVE ON NOVEMBER 1, 2010.

2. ALL ***MEMBERSHIP FEES*** WILL BE COLLECTED ON THE ***FIRST OF EVERY MONTH*** AND FORWARDED TO COPS AND KIDS MANAGEMENT ***THE SAME DAY***.

3. COPS AND KIDS MANAGEMENT RESERVES THE RIGHT TO USE DESCRETION ON A CASE-BY-CASE BASIS.

4. EACH MEMBER IS RESPONSIBLE FOR THE EQUIMENT THAT IS THE PROPERTY OF COPS AND KIDS.

5. NO SPITTING ON THE FLOOR.

6. ANYONE CAUGHT STEALING FROM THE COPS AND KIDS OR ANYONE PERSON WILL BE REMOVED AND PERMANTLY BANNED FROM THE PROGRAM.

7. WHEN TRAINING, MEMBERS MUST BRING THEIR OWN TOWELS AND PERSONAL BELONGINGS.

8. WHILE TRAINING INSIDE THE RING YOU MUST WEAR THE PROPER RING SHOES OR SNEAKERS. NO STREET FOOTWEAR WILL BE ALLOWED TO BE WORN ON THE FLOOR OR IN THE RING.

9. WHILE SPARRING IN THE RING, YOU MUST WEAR HEAD GEAR, CUP, & MOUTHPIECE. – ***NO EXCEPTIONS!!!***

10. COPS AND KIDS AND OR ITS MANAGEMENT ARE NOT RESPONSIBLE FOR YOUR EQUIPMENT OR BELONGINGS.

11. ANYTHING LEFT IN THE LOCKER/DRESSING ROOM WILL BE DISPOSED OF UPON CLOSING IF NOT CLAIMED.

12. COPS AND KIDS RESERVES THE RIGHT TO REMOVE ANYONE FROM THE PROGRAM, INCLUDING BUT NOT LIMITED TO TRAINERS/BOXERS, ETC. FOR FAILURE TO COMPLY WITH THESE RULES AND REGULATIONS.

DUES: $25 / YR

Name_____ Name_____
(PRINT) (Signature)

Name_____ Name_____
(PRINT) (Parent or Guardian) (Signature) (Parent or Guardian)

Date_____

Revised: July 1, 2017

SPORTS EXAMINATION - CONFIDENTIAL

NAME: _____ SCHOOL: _____ BOROUGH: _____
ADDRESS: _____ GRADE: _____
_____ DATE OF BIRTH: _____
TELEPHONE: _____ EMERGENCY TELEPHONE: _____
SPORT: _____

PARENTAL PERMISSION: I have reviewed the STUDENT MEDICAL HISTORY section below and I agree with the answers. I give permission for _____ to have a physical examination.

SIGNATURE: _____
DATE: _____ RELATIONSHIP: _____
********** **********

CLINICIAN'S RECOMMENDATIONS
Based on my review of the history and physical examination as noted below and on the back of this form, and review of the guidelines for this student:
(1) May participate in the following sports:
DRAW A LINE TRHOUGH ANY SPORTS TO BE OMITTED:

CONTACT	ENDURANCE	OTHER
Boxing		
Football	Gymnastics	Bowling
Baseball	Swimming	Golf
Basketball	Track & Field	Crew
Soccer	Cross-country	Cheerleading
Hockey	Tennis	Field Events
Wrestling	Volleyball	Archery
Lacrosse	Handball	
Softball	Fencing	
Cricket	Double Dutch	
Rugby		

DATE OF LAST TETANUS BOOSTER: _____
(2) Special conditions for participation (e.g., pre-exercise medication or protective equipment), if any:
DATE: _____ SIGNATURE: _____
(CLINICIAN)
TELEPHONE: _____ NAME: (PRINT) _____
REGISTRY #: _____ ADDRESS: _____
_____

STUDENT'S MEDICAL HISTORY
(To be filled out by student and parent) Clinician's Comments
Has anyone in your family under age 45 died suddenly Yes ___ No ___
Have you ever had:
Concussion or been knocked out? Yes ___ No ___
Fainting? Yes ___ No ___
Heat Stroke? Yes ___ No ___
Epilepsy, seizures, or fits? Yes ___ No ___
Head or neck injury? Yes ___ No ___
Very bad vision in one or both eyes? Yes ___ No ___
PART 1 to be filed in
Student's Health folder
Do you wear glasses, contacts, other? Yes ___ No ___
Have you ever had:
Hearing loss or deafness? Yes ___ No ___
Perforated ear drum or "tubes" in ears? Yes ___ No ___
Draining ears? Yes ___ No ___
PART 1 – STUDENT'S HEALTH FOLDER
STUDENT'S MEDICAL HISTORY CONTINUED:
(To be filled out by student and parent) Clinician's Comments
Have you ever had:
Sinus problems or hay fever? Yes ___ No ___
Braces or removable teeth? Yes ___ No ___

Have you ever had:
Any broken bones? _____ Yes ___ No ___
Dislocation or other serious problems? Yes ___ No ___
Serious foot problem? Yes ___ No ___
Back injury or frequent backaches? Yes ___ No ___
Ankle or knee injury or problem? Yes ___ No ___
Other joint problems? Yes ___ No ___
Do you have a hernia? Yes ___ No ___
Boys: Any problems with testicles? Yes ___ No ___
Girls: Any menstrual problem? Yes ___ No ___
Age at first menstrual period? _____
Do you miss school because of your period? Yes ___ No ___
Have you ever had:
Diabetes? Yes ___ No ___
Single illness for more than 10 days? Yes ___ No ___
Any operations? Yes ___ No ___
Easy bruising or bleeding tendency? Yes ___ No ___
Anemia? Yes ___ No ___
Asthma? Yes ___ No ___
Bee sting allergy? Yes ___ No ___
Other allergies (food or medicine) Yes ___ No ___
Heart trouble or murmurs? Yes ___ No ___
High blood pressure? Yes ___ No ___
Cough lasting more than 3 weeks? Yes ___ No ___
Chest pain or faintness with exercise? Yes ___ No ___
Kidney problems? Yes ___ No ___
Skin infections? Yes ___ No ___
Do you take any medicines? Yes ___ No ___
Do you smoke? Yes ___ No ___
Have you ever been told not to play any sport
because of your health? Yes ___ No ___
****

PHYSICAL EXAMINATION
A complete physical examination for all students is recommended. Omission of the Maturation Index will not disqualify a student from participation.
Height: _____ Weight: _____ Pulse: _____ Blood Pressure: _____
Vision Uncorrected: L20/_____ R20/_____ Corrected: L20/_____ R20/_____
Normal Abnormal Comments
Skin _____ _____ _____
Eyes _____ _____ _____
ENT _____ _____ _____
Mouth & Teeth _____ _____ _____
Neck _____ _____ _____
Cardiovascular _____ _____ _____
Lungs, Chest _____ _____ _____
Spine _____ _____ _____
Abdomen _____ _____ _____
Genitalia (Hernia) _____ _____ _____
Maturation Index _____
Extremities
Orthopedic _____ _____ _____
Neuromuscular _____ _____ _____
Other tests, if done (Lab, ECC, ect.)
Assessment: Plan:
GUIDELINES FOR DISQUALIFYING CONDITIONS FOR SPORTS PARTICIPATION

CONDITIONS CONTACT NONCONTACT ENDURANCE OTHER

Acute infections:
Respiratory, genitourinary, infectious mononucleosis,
hepatitis, active rheumatic fever, active tuberculosis,

boils, furuncles, impetigo – YES NO
Obvious physical immaturity in comparison with –
other competitors – YES NO
Obvious growth retardation – YES NO
Hemorrhagic disease – YES NO
Hemophilia, purpura, and other bleeding tendencies – YES NO
Diabetes, inadequately controlled – YES NO
Jaundice, whatever cause – YES
EYES – YES NO
Absence or loss of function of one eye – YES NO
Sever myopia, even if correctable
EARS – YES NO
Significant impairment - YES NO
RESPIRATORY – YES NO
Tuberculosis (active or under treatment) – YES NO
Severe pulmonary insufficiency
CARDIOVASCULAR – YES NO
Rheumatic heart disease coaretation or aorta, cyanotic
heart disease, recent carditis or any etiology – YES NO
Hypertension on organic basis – YES NO
Significant residual heart disease following heart surgery
for congenital or acquired heart disease – YES NO
LIVER, enlarged – YES NO
SPLEEN, enlarged – YES NO
HERNIA, inguinal or femoral – YES NO
MUSCULOSKELETAL
Symptomatic inflammation – YES NO
Functional inadequacy incompatible with the contact or
skill demand of the sport – YES NO
NEUROLOGICAL
History of symptoms of previous serious head trauma
or repeated concussions – YES NO
Convulsive disorder not completely controlled by medication - YES NO
Previous surgery on head or spine – YES NO
RENAL
Absence of one kidney – YES NO
Renal disease – YES NO
GENITALIA – YES NO
Absence of one testicle – YES NO
Undescended testicle – YES NO

The Guidelines for Disqualifying Conditions for Sports Participation listed on this form serve only as recommendations to the examining physician. The decision as to whether a student is qualified to participate should be individualized. In case of differences of interpretation the decision of the school physician has precedence. Appeals may be requested through established procedures.

IMPORTANT NOTICE TO PARENTS / GUARDIANS!

We require every student to have a physical examination before participating in physical sport activity. The physical examination and the Sport Examination form may be completed by the your primary care physician. The purpose of this form is to ensure that your child receives a complete physical examination prior to participating in sports. The American Academy of Pediatrics, strongly recommend that every student have a complete physical examination including the prior to competing in athletics.

The term “clinician”, appears on the Sports Examination form and refers to physicians, nurse-practitioners and physicians’ assistant. The physical examination may be performed by any of these medical personnel. As the Sports Examination form indicates, the student’s medical record is strictly confidential and is on file in the our offices. The student’s medical record is not part of his, and is not subject to examination by anyone except authorized personnel.

PLEASE NOTE: ALL STUDENTS SHOULD RECEIVE REGULARLY SCHEDULED COMPLETE PHYSICAL EXAMINATION BY A PHYSICIAN OF THE PARENT/GUARDIAN’S CHOICE.