Sports & Fitness Training Application and Agreement

This agreement is made this _____ day of _____, _____ between Top Shelf Performance, LLC and those persons whose names are set forth below, after the captions "Member's Name," for use of the Top Shelf Performance Training Facility during specified hours.

Primary Member Information ***(Completed by Applicant)***

Name:_____
Last Name First Middle Initial

Home Address:_____
Address City State Zip

E-Mail:_____

Phone # (Home):_____(Work):_____(Cell)_____

Birthday:_____month____day____year (optional) Gender:____male____female (optional)

In case of an emergency, contact:_____
Name Relationship Phone

How did you hear about us?

__Magazine __Newspaper Ad __USA Hockey __FaceOff Ad __Hospital
__Website __Radio __Physical Therapist __Doctor __Chiropractor
__Direct Mail __Family/Friends __Sports Clinic __School __Teammate/other athlete
__Other_____

Do you wish to receive our FREE Monthly e-newsletter, packed with tons of training info? Yes / No

Waiver and Release *(Signed by Applicant and Parent/Guardian if under 18 years of age)*

I agree to abide by the rules of Top Shelf Performance, including completion of a pre-activity screening questionnaire and/or health/medical information questionnaire prior to participation in any physical activities at the Top Shelf Performance (TSP) facilities. I further agree that all use of the TSP facilities, programs and services shall be undertaken at my sole risk and that TSP shall not be liable for any injuries, accidents, or death occurring to me, including those resulting from TSP's negligence arising either directly or indirectly out of my participation in TSP's facilities, programs, and services, including those resulting from TSP's negligence. I for myself and on behalf of my executors, administrators, heirs, and assigns, do hereby expressly release, discharge, waive, relinquish, and covenant not to sue TSP, its affiliates, officers, directors, agents or employees for all such claims, demands, injuries, damages or causes of action, including those resulting from TSP's negligence, arising either directly or indirectly out of my participation in, or use of, TSP's facilities, programs and services.

I declare that I have completed TSP's pre-activity screening questionnaire and/or health/medical information questionnaire and that I am physically able to participate in physical activity. Furthermore, I acknowledge that TSP has advised me to obtain a physician's clearance in the event the answers on either the pre-activity screening questionnaire and/or health/medical information questionnaire indicates that I should not participate in a program of physical activity without a physician's clearance, or if TSP is unsure of my physical health, yet I maintain that I am physically capable of pursuing physical activity in the TSP facility.

Member's Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

TSP Staff Signature:_____ Date:_____

Health History (Information) Questionnaire

Please complete this form in its entirety and give it to a Top Shelf Performance Coach.

Name:_____Gender:_____Birthdate:_____
Address:_____
Phone (H):_____(W):_____(C):_____
E-Mail:_____Fax:_____

Regular physical activity is enjoyable and healthy, and for most people, safe. However, some individuals may have health risks that might require them to check with their physician prior to starting an exercise/performance training program. To help determine if there is a need for you to see your physician before starting an exercise/performance training program, carefully read and answer the following questions. All information will be kept strictly confidential.

I. PHYSICAL ACTIVITY SCREENING QUESTIONS (Please answer yes or no to each of the following)

Yes No 1. Has your physician ever told you that you have a heart condition?
Yes No 2. Do you experience chest pain when you are physically active?
Yes No 3. In the past month, have you experienced chest pain when not performing 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 aggravated by a change in your level of physical activity?
Yes No 6. Is your physician currently prescribing medication for your blood pressure or heart condition?
Yes No 7. Do you know of any other reason why you should not participate in a program of physical activity?

If you answered yes to any of the questions above, it is recommended that you consult with your physician, by phone or in person, before having a fitness/performance evaluation and/or participating in a physical activity/performance training program.

II. GENERAL HEALTH HISTORY QUESTIONS (Please answer yes or not to each of the following)

Yes No 1. Have you ever had a stroke?
Yes No 2. Do you have diabetes? If yes, are you currently taking any medications or receiving other treatment related to diabetes? Yes No
Yes No 3. Do you have asthma or another respiratory condition that causes difficulty with breathing?
If yes, please describe:_____
Yes No 4. Do you have any orthopedic conditions that would restrict you in performing physical activity?
If yes, please describe:_____
Yes No 5. Have you ever been told by a physician that you have one of the following?
(Circle all that apply)
High Blood Pressure
Elevated blood lipids, including elevated cholesterol
Cardiovascular disease
Cancer
Other health/medical condition (please describe):_____
Yes No 6. Do you currently smoke or have you smoked in the past and stopped within the past six months?
Yes No 7. Do you currently have back pain or have you had back pain within the past six months or felt discomfort that prevented you from carrying out normal daily activites?
Yes No 8. Are you currently taking any medications for a health or medical condition? If yes, please indicate which medications you are taking._____
Yes No 9. Are you pregnant?

If you answered yes to any of the questions above, it is recommended that you consult with your physician, by phone, or in person, before having a fitness/performance evaluation and/or participating in a prescribed physical activity program. In some instances, depending upon the answers you provided to the questions above, you may be required to obtain a physician's written clearance before an exercise/performance training program can be designed for you.

Client Commitment Identification Form

(Completed by the Athlete/Fitness Client)

Athlete/Fitness Client Name:_____

School/Team(s):_____

Athlete's Sport(s):_____Position:_____

Athlete's Coaches:_____

Athlete's Availability (Days per week you are committed to performance/fitness training):_____ _

Previous Injuries (List all, including known dates):_____
_____
_____

Known Exercise Restrictions/Limitations:_____
_____

In terms of athletic performance or fitness, what do you think is your greatest weakness?_____
_____

Your greatest strength?_____
_____

In your own words, define success (what it means to you)?_____
_____

What are you willing to give up, to sacrifice to achieve success (your goals)?_____
_____

Name 2 Short-term athletic goals, and 2 long term athletic goals:_____
_____
_____
_____
_____
_____

How do you plan on achieving these goals? (use the back of this page if needed):_____
_____
_____

What do you do every day to get better, and get closer to your goals?:_____
_____
_____
_____