



**Harmarville
Outreach Programs
and Educational
Network**

REGISTRATION FORM

Name: _____ Age: _____ Male/Female: _____ D.O.B.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (day) _____ (evening) _____ E-mail _____

Employer: _____ Occupation: _____ Work Hours: _____

Do you have a physical disability? Yes ____ No ____ If yes, please provide the following information:

Disability: _____ Date of Onset: _____

Assistive Devices Used: _____

Movement Limitations: _____

Medical Precautions: _____

Please indicate if you have any of the following:

| | | | |
|---|--|--|--|
| <input type="checkbox"/> Cardiac Disorder | <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pulmonary Disorder |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Fainting | <input type="checkbox"/> Dizziness | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Other Medical | <input type="checkbox"/> Joint/Bone Problems | | |

Please describe any items checked above: _____

Medications currently taking: _____

List the sports/fitness activities you participate in: _____

c:Hlthsprts/Forms/Reg