



FOR YOUTH DEVELOPMENT®  
FOR HEALTHY LIVING  
FOR SOCIAL RESPONSIBILITY

## Randolph YMCA Aquatic Rehabilitation/Training Intake Form

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City, State & Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Text? Yes / No

**Can you swim?** Yes / No Email \_\_\_\_\_

**Do you participate in any recreational activities? (Golf, Swimming, Skiing, etc.)** Yes / No

Explain \_\_\_\_\_

**Have you ever had any surgeries?** Yes / No

Explain \_\_\_\_\_

**Has a Medical Doctor ever diagnosed you with a Chronic Disease, such as Coronary Heart Disease (CHD), Coronary Artery Disease (CAD), Hypertension (High Blood Pressure), High Cholesterol, Diabetes, etc.?**

Yes / No Explain \_\_\_\_\_

**Do you have any bone or joint problems?** Yes / No

Explain \_\_\_\_\_

**Are you currently taking any medications?** Yes / No

Explain \_\_\_\_\_

**What goals are most important to you to accomplish with an Aquatic Rehabilitation/Training Program?**

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**RANDOLPH YMCA**

14 Dover Chester Road, Randolph NJ 07869

P 973 366 1120 F 973 366 8025 randolphymca.org

Revised 9/12/2017



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## Randolph YMCA Personal Training Policies

1. Please be ready to begin each training session at the scheduled appointment time. If you arrive late, the training session will not be extended.
2. All sessions must be paid in full in advance at the front desk.
3. A 24-hour notice of cancellation is required, should you wish to cancel a training session. If a session is canceled less than 24 hours prior, the client will be charged the full training amount.
4. Should you wish to reschedule an appointment, the trainer will do his/her best to accommodate your request. All requests must be made at least 24 hours in advance.
5. Ten session packages are non-refundable.

By signing below, I understand and agree to the above policies.

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Trainer's Name (Please Print)

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Trainer's Signature

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Date

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Client's Name (Please Print)

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Client's Signature

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Date

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## Randolph YMCA Medical Clearance Form

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ City, State & Zip \_\_\_\_\_

Your patient \_\_\_\_\_, has applied to participate in a  
\_\_\_\_\_ program. Please provide any restrictions or  
medications your patient is currently taking which may affect his/her workout.

**Please list any restrictions, modifications or recommendations for your patient's program:**

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

**Please list any medications & how they may affect your patient's workout:**

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

Sincerely,

\_\_\_\_\_

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My patient \_\_\_\_\_, has my approval to participate in a program with the  
above restrictions, modifications and recommendations.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

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## Randolph YMCA Aquatic Personal Training Inquiry

Date \_\_\_\_\_ Time \_\_\_\_\_ Membership # \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City, State & Zip \_\_\_\_\_

Email \_\_\_\_\_

**Please check off the phone number that is best to contact you:**

Home Phone # \_\_\_\_\_  Cell Phone # \_\_\_\_\_

**Reasons/Goals** \_\_\_\_\_  
\_\_\_\_\_

**Medical Condition/Diagnosis** \_\_\_\_\_  
\_\_\_\_\_

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**FOR OFFICE STAFF**

Department Assigned—Aquatic PT

Date of Follow up Call \_\_\_\_\_ Staff Name \_\_\_\_\_

Trainer Assigned \_\_\_\_\_

Scheduled Appointment Date \_\_\_\_\_

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