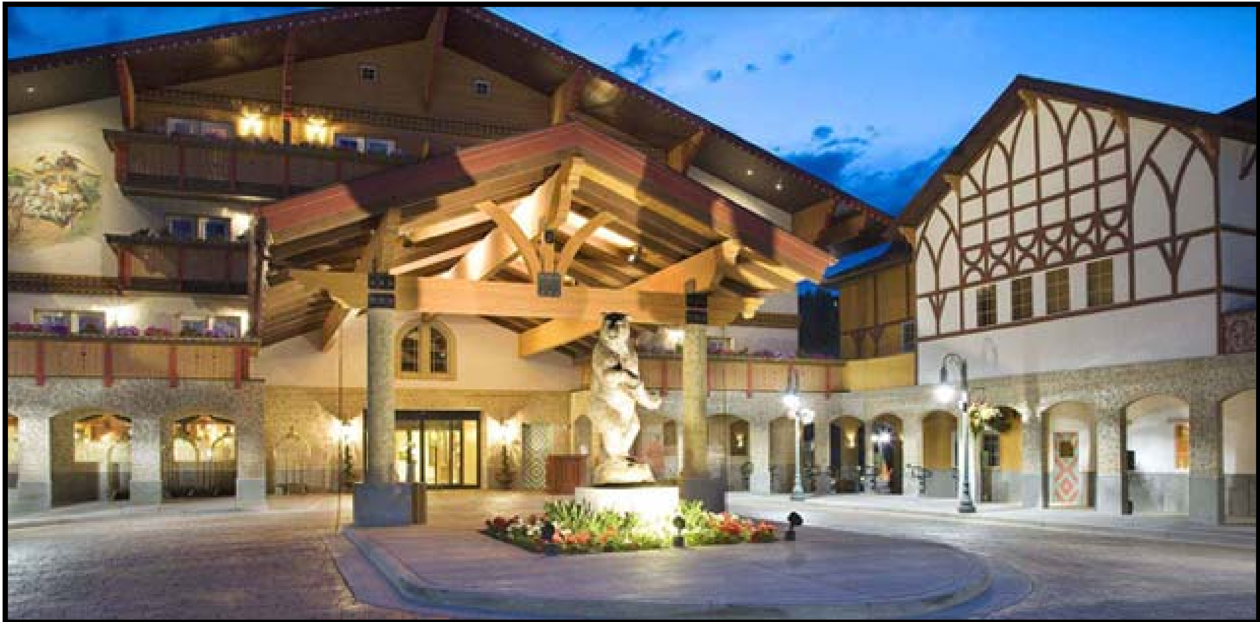
Registration Packet

Weekend Health & Fitness Retreat



Please complete forms and send to:

Lockdown Health & Fitness, Inc.
1912 South Berkeley Street
Salt Lake City, UT 84108

Or email completed packet to:
retreats@lockdownhealthandfitness.com

Dear Participant,

Thank you for choosing LOCKDOWN Health & Fitness at the Zermatt Resort & Spa and welcome to our health & fitness retreats! We are excited for you to attend your weekend get-a-way and hope you enjoy your program and stay.

As you may know, a LOCKDOWN representative will be calling you to confirm you reservation and accommodate any special needs that you may have. Please complete the forms in this packet and return them to:

Lockdown Health & Fitness, Inc.
1912 South Berkeley Street
Salt Lake City, UT 84108

Or email completed packet to:
retreats@lockdownhealthandfitness.com

We look forward to meeting you and wish you a safe journey to the Zermatt Resort & Spa. Please don't hesitate to call if you have any questions or concerns at (801) 830.4916.

Sincerely,

Darrin Cottle, Owner
LOCKDOWN Health & Fitness

General Agreement

Terms & Conditions

Retreat participants will be staying at the Zermatt Resort & Spa located at 784 West Resort Drive in Midway, Utah. A map as well as driving directions has been provided in this packet. Participants are responsible for traveling to and from the resort facility. **LOCKDOWN Health & Fitness Inc will NOT be held liable or responsible for any damages, costs, injuries, and/or death that occur while traveling to or from the retreat location.** _________ *initial*

Participants are responsible for bringing adequate and appropriate attire for this health retreat. A check-list has been included in this packet to facilitate the packing process. **LOCKDOWN Health & Fitness Inc will NOT be held liable for any lost or damaged personal property items (i.e. cell phones, Ipods, luggage etc).** To minimize distractions, cell phones must be left on silent mode. _________*initial*

LOCKDOWN Health & Fitness Inc. provides participants with all meals and snacks during the health retreat. In addition, all standard hotel accommodations (i.e. hotel room, fitness facility etc) are included in the package price. Any additional and unexpected hotel charges such as pay per view, room service, and/or spa treatments are not included in the retreat package price and will be billed to participants for payment. _________ *initial*

Payment for health retreats is due at the time of booking. Reservations may be cancelled for a full-refund **less a $25 cancellation fee** if cancelled seven calendar days (one week) in advance. There will be no refunds issued for cancellations that take place less than seven days prior to the scheduled retreat. Cancellations may take place via telephone by calling (801) 830-4916 or with written submission to address listed. LOCKDOWN reserves the right to reschedule your retreat for another date and time if enrollment is below 4 participants. _________*initial*

☐ *By signing this general agreement form, I agree to the above written terms and conditions.*

____
Name [Print]

____ _____________
Signature Date

Location of **Health Retreat:**
Zermatt Resort & Spa, Midway, Utah

Agreement & Release of Liability

Legal Document

I, *the undersigned*, understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, are potentially hazardous activities. I also understand that fitness activities involve the risk of injury and even death, and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury and/or death. **IF YOU UNDERSTAND THE AGREEMENT AND AGREE, PLEASE INITIAL _______**.

I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity or other illness that would prevent my participation or use of equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise and use of exercise and training equipment so that I might have his recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given my physician's permission to participate, or that I have decided to participate in activity and use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities. **IF YOU UNDERSTAND THE AGREEMENT AND AGREE, PLEASE INITIAL _______**.

In consideration of being allowed to participate in the activities and programs of "Lockdown Health & Fitness, Inc." and to use its facilities, equipment and activities, in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge "Lockdown Health & Fitness, Inc." and its directors, officers, agents, employees, representatives, successors, and assigns, administrators, executors, and all others from any and all responsibilities or liability from injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above mentioned activities. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of "Lockdown Health & Fitness" including the use of any equipment. **IF YOU UNDERSTAND THE AGREEMENT AND AGREE, PLEASE INITIAL _______**.

_________________________________	______/______/______
Participant's Name: (Please Print)	***Birthdate:***
_________________________________	______/______/______
Participant's Signature:	***Date:***

Health History Form

GENERAL INFORMATION:

Name: ______________________ Date of Birth: ____/____/____ Age: ______

Address: ______________________ Home Phone: (____)______________

City/State: ______________________ Cell Phone: (____)______________

Email Address: ______________________ Sex: ______ Allergies: ______________

Height: _____' _____" Current Weight: ________ lbs

In Case of Emergency, Contact: ______________ Phone: (____)________ Relationship: ________

Physician: ______________________ Specialty: ________ Phone: ____________

HEALTH INFORMATION:

- Are you currently under a doctor's care? ☐ Yes ☐ No
  If yes, explain: ______________________
- When was the last time you had a physical examination? ______________________
- Have you ever had an exercise stress test? ☐ Yes ☐ No
  If yes, were the results: ______________________
- Are you currently taking any medications and/or dietary supplements? ☐ Yes ☐ No
  If yes, please list medications and reasons for taking: ______________________
  ____
  ____
- Have you been recently hospitalized? (past six months) ☐ Yes ☐ No
  If yes, please explain: ______________________
  ____
- Do you currently smoke? ☐ Yes ☐ No
  If yes, how many cigarettes per day? ______________________
  If in the past, describe your smoking history: ______________________
- Do you drink alcohol? ☐ Yes ☐ No
  If yes, how many drinks per day or how many times per week? ______________
- Is your stress level high? ☐ Yes ☐ No
- Are you moderately active (30 min/day) on most days of the week? (4 or more days) ☐ Yes ☐ No
- Are you pregnant? (women only) ☐ Yes ☐ No
- Do you have: (if so, state levels and/or form)
  High blood pressure? ☐ Yes ☐ No
  High cholesterol? ☐ Yes ☐ No
  Diabetes? ☐ Yes ☐ No
- Do you have parents or siblings who, prior to age 45, had:
  A heart attack? ☐ Yes ☐ No
  A stroke? ☐ Yes ☐ No
  High blood pressure? ☐ Yes ☐ No
  High cholesterol? ☐ Yes ☐ No

Health History Form (Cont.)

HEALTH INFORMATION CONT:

- Do you have or experience any of the following?

Known heart disease?	☐ Yes ☐ No	Rheumatic heart disease?	☐ Yes ☐ No
A heart murmur?	☐ Yes ☐ No	Chest pain with exertion?	☐ Yes ☐ No
Irregular heart beat or palpitations?	☐ Yes ☐ No	Lightheadedness or do you faint?	☐ Yes ☐ No
Unusual shortness of breath?	☐ Yes ☐ No	Cramping pains in legs or feet?	☐ Yes ☐ No
Emphysema?	☐ Yes ☐ No	Epilepsy?	☐ Yes ☐ No
Other metabolic disorders (thyroid, kidney, etc)?	☐ Yes ☐ No	Asthma?	☐ Yes ☐ No

- Back pain? If yes, please describe: ☐ Yes ☐ No

____

____

____

- Other Joint Pain? If yes, please describe: ☐ Yes ☐ No

____

____

____

- Muscle Pain or injury? If yes, please describe: ☐ Yes ☐ No

____

____

____

- Please **list** and **describe** your previous exercise habits within the past six months:

____

____

____

To the best of my knowledge, the above information is true.

Signature ______________________________ **Date:** _____/______/________

[For Office Use Only]:

- Number of Present Risk Factors: ___
- Risk Factor Status:
  - ☐ Low Risk
  - ☐ Moderate Risk
  - ☐ High Risk

LOCKDOWN *Health & Fitness, Inc.* – 1912 S. Berkeley St. – Salt Lake City, Utah 84108 – Phone: (801) 830-4916

Visit us online at www.lockdownhealthandfitness.com

FitMarkers Questionnaire

GENERAL INFORMATION:

Name: ______________________________ Date of Birth: ____/____/____ Age: ________

Address: ______________________________ Home Phone: (_____)____________________

City/State: ______________________________ Cell Phone: (_____)____________________

Email Address: ______________________________ Sex: ________ Allergies: ____________________

Height: ____’ ____” Current Weight: ________ lbs

FAMILY HISTORY:

- Has one or more close family member(s) been diagnosed with coronary heart disease? ☐ Yes ☐ No
- Has one or more close family member(s) been diagnosed with high blood pressure/hypertension? ☐ Yes ☐ No
- Has one or more close family member(s) suffered a stroke? ☐ Yes ☐ No
- Has one or more close family member(s) been diagnosed with diabetes mellitus? ☐ Yes ☐ No

GENERAL HEALTH:

- When was your last physical examination? (check appropriate box)
  ☐ Within six months? ☐ Within one year? ☐ Over one year?

- How would you describe your health?
  ☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Excellent
  ☐ better with medical management and/or medications

- Is your resting blood pressure greater than or equal to 140/90 mm Hg? ☐ Yes ☐ No ☐ Unknown
- Is your serum cholesterol level > 200mg/dL? ☐ Yes ☐ No ☐ Unknown
- Has your physician determined your cholesterol/HDL ratio? ☐ Yes ☐ No ☐ Unknown
- Have you been diagnosed with CHD? ☐ Yes ☐ No
- Have you suffered a stroke? ☐ Yes ☐ No
- Do you suffer from any stress-related symptoms? ☐ Yes ☐ No
  - Extreme nervousness? ☐ Yes ☐ No
  - Problems sleeping? ☐ Yes ☐ No
  - Problems maintaining weight? ☐ Yes ☐ No
  - A consistently high resting heart rate? ☐ Yes ☐ No ☐ Unknown

- Have you experienced any of the following symptoms in the past month?
  - Chest pains when physically inactive or when physically active ☐ Yes ☐ No
  - Shortness of breath climbing a flight of stairs ☐ Yes ☐ No
  - Dizziness when rising from bed or a chair or anytime throughout the day ☐ Yes ☐ No
  - A loss of consciousness ☐ Yes ☐ No
  - Have you been diagnosed with diabetes mellitus? ☐ Yes ☐ No

    If yes, ☐ Type 1 ☐ Type 2

FitMarkers Questionnaire (Cont.)

SPECIAL HEALTH CONSIDERATIONS:

- Have you had any surgeries within the past year? ☐ Yes ☐ No
  If so, please state reason: ___________________________

- Do you have any of the following limiting physical conditions?
  - Pregnancy ☐ Yes ☐ No
  - Muscular dystrophy ☐ Yes ☐ No
  - Nerve or sensory damage ☐ Yes ☐ No
  - Multiple Sclerosis ☐ Yes ☐ No
  - Other ____________________ ☐ Yes ☐ No

- Do you suffer from any of the following limiting orthopedic conditions?
  - Arthritis ☐ Yes ☐ No
  - Bursitis ☐ Yes ☐ No
  - Broken Bones ☐ Yes ☐ No
  - Stress fractures ☐ Yes ☐ No
  - Prosthesis (hip, knee replacement, etc.) ☐ Yes ☐ No
  - Other ____________________ ☐ Yes ☐ No
  ☐ Yes ☐ No

- Are you on any of the following medications?
  - Heart medications ☐ Yes ☐ No
  - Hypertensive medications ☐ Yes ☐ No
  - Asthma medications ☐ Yes ☐ No
  - Insulin injections ☐ Yes ☐ No
  - Water pills ☐ Yes ☐ No
  - Other ____________________ ☐ Yes ☐ No
  ☐ Yes ☐ No

ENVIRONMENT AND LIFESTYLE FACTORS:

- Do you tend to eat meals high in dietary fat? ☐ Yes ☐ No
- Are you sedentary (do not exercise at all)? ☐ Yes ☐ No
- Do you exercise less than three to five times per week on a regular basis? ☐ Yes ☐ No
- Do you sleep less than six hours per night? ☐ Yes ☐ No
- Do you drink more than two glasses of alcohol per day? ☐ Yes ☐ No
- Do you currently smoke cigarettes? ☐ Yes ☐ No
- Were you a heavy smoker who recently quit? ☐ Yes ☐ No

- How would you describe your fitness ability?
  ☐ Poor ☐ Fair ☐ Average ☐ Good
  ☐ Excellent

To the best of my knowledge, the above information is true.

Signature ____ **Date:** _____/______/________

[For Office Use Only]:

- Number of Present Risk Factors: ___
- Risk Factor Status:
  ☐ Low Risk
  ☐ Moderate Risk
  ☐ High Risk

Physician's Clearance Form

PATIENT INFORMATION:

Date of Last Physical Examination: ______/______/________

Patient's Name: ____ Date of Birth: _______/________/________ Age: __________

Address: ____ Sex: _________ Allergies: ______________________________

City/State: ____ Height: _____' _____" Current Weight: __________ lbs

PHYSICIAN INFORMATION:

Physician: ____ Office Phone: (_____)______________________________

Clinic Address: ____ Fax: (_____)______________________________

City/State: ____ Cell/Pager: (_____)______________________________

[FOR PHYSICIAN USE ONLY]:

Check the appropriate box:

- ☐ This patient may participate in a three-day health & fitness retreat that includes a physical activity program consisting of cardiovascular, strength, and flexibility training within normal limitations and fitness guidelines.
- ☐ This patient may participate in a three-day health and fitness retreat that includes a physical activity program with the following limitations and/or recommendations. *You may use the back of this form if needed*:

____

____

* *Please include a brief description of any medical condition that might affect his/her three-day health and fitness retreat, including nutritional and physical activity-related conditions. You may use the back of this form if needed:*

____

____

* *If this patient is on any medication that may affect the heart rate or the blood pressure response to exercise (elevating or suppressing), please indicate. You may use the back of this form if needed:*

____

____

* Please fill in the following information: (if available)

Result of last GXT: _______ Total Cholesterol: _______ Triglycerides: _______ Glucose Tolerance: _______
Blood pressure: _______ HDL-C: _______ LDL-C _______

* I consider the above individual to be: ☐ normal ☐ at risk for cardiovascular disease ☐ cardiac patient ☐ other (explain)

____ ____________

Physician's Signature ***Date***

Please Note: This record must be **stamped** with a physician's official stamp or be accompanied by a typed letter on physician's **letterhead**, documentin that a medical evaluation has been performed on the named client. The physician's clearance form WILL NOT BE ACCEPTED WITHOUT SUCH PROPER VERIFICATION.

Please return this form to:

LOCKDOWN *Health & Fitness Inc.*
Attention: Darrin Cottle
1912 South Berkeley St.
Salt Lake City, UT 84108

Physician's Clearance Form (Cont.)

PATIENT WAIVE OPTION:

I, ________________________________, reserve the right to waive this physician's clearance form and hereby declare myself low-risk and physically able in all aspects and bodily functions to engage and participate in a three-day health and fitness retreat. I understand that LOCKDOWN *Health & Fitness, Inc* may refuse its services to me if I do not provide them with this physician's clearance form.

___________________________________ _____/____/_____
Signature of patient Date

** Only if making a reservation offline*

Credit Card Authorization Form

Cardholder Name: ____ Date: _______________

Description of Service or Purpose for Charge: ____

____

Retreat Price:	$ ____________.
Processing Fee:	$ 10.00 ________.
Total Amount Authorized to Charge:	$ ____________.

Cardholder Billing Address:

Street: ____

City:______________________________ State: _______________ Zip Code: ___________

Email: ____ Phone: ______________

Type of Card: ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number: ____ Exp. Date: __________

Security Code Number: ____ ____ ____

(This number is 3 digits and is the non-embossed number printed on the signature panel on the back of your card immediately following the card acct number. This number is recorded as an additional security precaution)

☐ I, *the above cardholder*, authorize LOCKDOWN *Health & Fitness, Inc* to bill my credit card for the above mentioned amount and service.

Signature of Cardholder: ____ Date: __________________

LOCKDOWN *Health & Fitness, Inc.* – 1912 S. Berkeley St. – Salt Lake City, Utah 84108 – Phone: (801) 830-4916

Visit us online at www.lockdownhealthandfitness.com

Things to Bring!

You will be staying at a four-star hotel in a mountain community setting. Please make sure you bring adequate clothing and fitness attire as you will be engaging in outdoor recreation and fitness-related activities. You are encouraged to bring electronic devises that will help motivate and keep you focused (i.e. heart rate monitor, IPod, and/or camera) but please leave your laptop computer at home! ***Remember, LOCKDOWN will not be held responsible for any lost or stolen items.***

For this health retreat, we want to create a safe and effective learning environment; therefore, we would ask that you leave your cell phones at home or at least in your hotel rooms. This will help reduce and minimize any outside distractions and keep you focused on your health improvements!

Suggested Items:

- ☐ Exercise Clothes (at least 3-4 different pairs)
- ☐ Exercise shoes (for outdoor & indoor activities)
- ☐ Socks (at least 4 pair)
- ☐ Toiletries (i.e. toothbrush, lotion, hair products etc)
- ☐ Coat/Jacket/Sweater (weather appropriate)
- ☐ Sunscreen
- ☐ Sun Glasses
- ☐ Small Back Pack (for outdoor hiking)
- ☐ Swimming Suit
- ☐ Light Hiking Shoes (not sneakers but not boots)
- ☐ Pool Shoes/Sandals
- ☐ Casual Clothes for restaurant (1 pair)
- ☐ Pajamas (for 2 nights)
- ☐ 3-Day Dietary Food Record (This is simply a written record of all of your food/drink intake for three full days)
- ☐ Yourself and a Positive Attitude!!!

Optional Items (Seasonal):

- ☐ Camera
- ☐ IPod or Mp3 Player
- ☐ Heart Rate Monitor
- ☐ Sweater/Jacket
- ☐ Light/Heavy Coat (Weather appropriate)
- ☐ Rain Jacket (weather appropriate)
- ☐ Anti-Blistering Socks
- ☐ Medication (if applicable)

** Please note: LOCKDOWN <u>will</u> provide all of your meals each day (breakfast, lunch and dinner) including an additional two snacks per day. You will not go hungry!*

** Any additional items such as souvenirs, unexpected hotel charges (i.e. pay per view or internet) are NOT included in the retreat package price.*

Address / Maps

Address:
Zermatt Resort & Spa
784 West Resort Drive
Midway, UT 84049
435.657.0180
435.657.0182