



REGISTRATION FORM

1. Please print out and **complete the entire form.**

2. **Please select Boot Camp choice:**

4 Week/5 Day Women's Boot Camp - \$299.00. Please select 5:30 a.m. or 9 a.m.

4 Week/3 Day Women's Boot Camp - \$200.00. Please select 5:30 a.m. or 9 a.m.

4 Week/2 Day Co-Ed Boot Camp - \$130.00.

Women's Retreat.

3. **Enclose registration and check** made payable to: The Wellness Coach, Inc. **Pay via credit card or Paypal from our web site.**

4. **Mail to: Wellness Coach Boot Camp_24325 Carlton Court,_Laguna Niguel, CA 92677**

Name: _____

Address: _____

Date of Birth: _____

Home Phone: _____ Cell Phone: _____

E-Mail: _____

Emergency Contact_Name _____

Emergency Phone Number: _____

Please complete the following questions to the best of your ability. Attach payment and mail to address listed above (#4).

Select one:

- I would rate my fitness level as a Beginner (has worked out 10 times or less in the last 12 month with resistance/cardio training).
- I would rate my fitness level as that of Intermediate (works out 2-3 times per week with resistance/cardio training).
- I would rate my fitness level as that of Advanced (works out 3-5 times per week with resistance/cardio training).

Please be specific in regard to training:

Medical History

Have you ever injured your back?	No _____ Yes _____ Describe _____ _____
Do you have back pain?	Never? _____ Occasionally? _____ Frequently with resistance training or cardio? _____
Do you have knee pain?	Never? _____ Occasionally? _____ Frequently with resistance training or cardio? _____
Do you have other physical conditions that cause pain?	No _____ Yes _____ Describe _____ _____ _____
Have you had any sprains or broken bones within the last year?	No _____ Yes _____ Describe _____ _____ _____
Have you ever had a neck injury?	No _____ Yes _____ Describe _____ _____

Have you had any surgical procedures?	No _____ Yes _____ Describe _____ _____
Do you have asthma?	No _____ Yes _____
Do you have high blood pressure?	No _____ Yes _____ List medications _____ _____
Do you have or have you ever had the following diseases?	
heart disease _____ diabetes _____ kidney disease _____ liver disease _____ lung disease _____	
Are you allergic to any medication?	No _____ Yes _____ Describe _____ _____
Do you take any prescribed medications?	No _____ Yes _____ List _____ _____
Do you have a seizure disorder?	No _____ Yes _____

How did you hear about The Wellness Coach Boot Camp?

Goals

What are your goals for the next month?

What are your goals for the next three months?

Are you training for a specific event? No _____ Yes _____

What event? _____

**WE RECOMMEND SEEKING YOUR DOCTOR'S ADVICE BEFORE
STARTING ANY EXERCISE PROGRAM!**

WAIVER

By signing this document, I acknowledge that I have been informed of the need to obtain a physician's examination and approval prior to beginning this exercise program. I fully understand that the program may be strenuous and choose to participate completely voluntarily. I accept all responsibility for my health and resultant injury or mishap that may affect my well-being or health in any way. I hold harmless of any responsibility the instructor, facility or any persons involved with this program or testing procedures.

I understand that I am responsible for my attendance and that there are no refunds for missed days. Should there be circumstance beyond my control, I am able to, at the discretion of the coach, receive credit for unused portions of camp to use on future Boot Camp days. Camp credit is subject to approval and availability in future camp.

Signature _____ Date _____

Print Name _____

Note: NO REFUNDS