ACCEL Original Program
Group of 4 Special
Team Registration Form

All information is confidential for ACMC use only—Please complete prior to initial evaluation.

Cost: $325.00 per person normally
$165.00 per person in groups of 4 for same sport

Team Registration Policy

- Program available to those 12 years of age or older.
- Team pricing: $165.00 individually for group of 4
- Price includes 18 visits of 60-90 minutes each (1 initial evaluation, 16 sport-specific workouts, and 1 re-evaluation)
- All unused appointments expire after 3 months from date of initial evaluation.
- Team Pricing: All registrations must be received using team registration sheet; All individuals of "team" must be in attendance together during each evaluation and workout; those individuals absent do not receive a makeup appointment.
- All visits by appointment only. Use team captain's name for scheduling purposes.

Team Captain Name (this will be your identifier for scheduling purposes): ______________________________

Please list each team member participating in the ACCEL Original Program
(4 people required for promotion).

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

NOTE: Each team member is required to complete the Participant Health Questionnaire/Parent Permission form on the next two pages.

NOTE: The completed *Team Registration Form* and all completed/signed *Participation Health Questionnaire/Parental Permission Forms* must be presented when making payment to cashier to receive team discount.

ACCEL Original
Participant Health Questionnaire
& Parental Permission Form

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Name (last, first) ____

Address: ______________________________ **City, State, ZIP**______________________________

Phone (____)______________________ **School** ______________________ **Birthdate** ___/___/___

Family Physician ______________________________ **Address** ______________________________

City, State, ZIP ______________________________ **Phone** ______________________________

Date of last Physical or Pre-Participation Examination ______________________________

Please list two individuals we may contact in case of emergency.

Name: ______________________________ **Relationship:** ____________ **Ph:** ______________

Name: ______________________________ **Relationship:** ____________ **Ph:** ______________

Have you experienced any of the following?

(Please explain all YES answers in the space provided on the back)

Y	N	
Y	N	Coughing, shortness of breath or chest pain?
Y	N	Numbness in any part of the body?
Y	N	Headaches, dizziness, weakness, fainting, or problems with coordination or balance?
Y	N	Difficulties with blurry vision?
Y	N	Problems with skin such as sores, rashes, itching or burning sensation, etc.?
Y	N	Stiffness, swelling or pain related to your muscles, bones or joints?
Y	N	Dehydration (excessive loss of water)?
Y	N	Heat stoke or other heat-related disorders?
Y	N	Head injury causing loss of memory, unconsciousness or vomitting?
Y	N	Epilepsy (Siesures)?
Y	N	Tuberculosis, asthma or any lung disease or respiratory disorder?
Y	N	Mononucleosis, diabetes, goiter or any other disease of the glands?
Y	N	Significant weight change in the past year?

For Office Use Only

PN: ____________

RN: ____________

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All information is confidential

FOR ACMC USE ONLY

ACCEL performance & fitness programs

CONTINUED FROM FRONT PAGE

Have you experienced any of the following? (cont'd)

(Please explain all YES answers in the space provided below):

Y	**N**	Hospitalization in the past 12 months for any reason?
Y	**N**	Current use of **any** medications?
Y	**N**	Use of nutritional supplements to aid training or performance?

Females only:

AT WHAT AGE DID YOU FIRST MENSTRUATE? ____________________

HOW REGULAR ARE YOUR PERIODS NOW? ____________________

ANY OTHER MENSTRUAL ABNORMALITIES OR CONCERNS AT THIS TIME ? ____________________

____

Use space below to explain "Yes" answers

____

____

____

____

____

____

My signature below certifies that the information provided above is true.

____________________ Participant's signature

____________________ Date

____________________ Parent's signature (Required if participant is a student)

____________________ Date