



Buff Mama

Personalized Fitness Training

REGISTRATION FORM FOR PRIVATE BOOT CAMPS

You can print this form and send it in by fax or mail. *NOTE: We cannot guarantee your space will be reserved if you do not supply us with a check payment sent with this form.

1. Print your information clearly or type
2. Fax to (808) 596-0940 or mail to: Buff Mama Inc., 350 Ward Avenue, Ste. 106-250, Honolulu, Hawaii 96814
If you are paying by check, please make payable to Buff Mama Inc.
3. You will be notified to schedule your pre-camp evaluation (if needed for your program).

Name: _____ Profession: _____

Street: _____ I rate my current fitness level as a _____ (1-10, ten=high).

City: _____ State: _____ Zip: _____

Date of Birth ___/___/___

Home Phone (_____) _____

Work Phone (_____) _____

Fax Number (_____) _____

E-mail _____@_____

I was referred by _____ Emergency Contact _____

MEDICAL HISTORY (If you are a returning camper, only complete the sections that have changed.)

- | | | |
|--|------------------------------|-----------------------------|
| 1. Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Do you take any prescribed medication on a permanent or semi-permanent basis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Do you have a seizure disorder (epilepsy)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Do you have diabetes Adult or Juvenile? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| List Medications: | | |
| 5. Have you ever been found to be anemic (low blood count)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Do you have High Blood Pressure (hypertension)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| List Medications: | | |
| 7. Do you have or have you ever had the following diseases? | | |
| Heart Disease: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lung Disease: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Disease: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Liver Disease: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Do you have asthma? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| List Medications: | | |
| 9. Have you ever had a severe neck injury? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Describe: | | |
| 10. Have you ever been knocked out? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Describe: | | |
| 11. Do you wear glasses or contact lenses? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Have you had a broken bone or fracture in the past 2 years? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Describe: | | |
| 13. Have you ever injured your back? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Describe: | | |
| 14. Do you have back pain? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Occasionally <input type="checkbox"/> Frequently with vigorous exercise or heavy lifting | | |
| 15. Have you had knee pain in the past 2 years that has disabled you for longer than a week? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Describe: | | |

16. Do you have other physical conditions which cause pain? Yes No
 Describe:
17. Detail any surgical procedures:
18. What are your goals for the next three months?
19. Have you had your body fat tested? Yes No
 If yes, what percent is it?
20. Are you training for a specific event? Yes No
 If yes, explain:
- *NOTICE: It is wise to seek your doctors advice before beginning any health/fitness/nutrition program!

RELEASE

This release is entered into between the undersigned and Dawn Quioko/Buff Mama, its officers, subsidiaries, affiliates, and executors in addition to the City of Honolulu and Kailua and any facility where training takes place. The purpose of Buff Mama Inc. is to provide fitness instruction and coaching for various levels of athletes/individuals.

The undersigned hereby acknowledge that the following was explained to me and/or agree to the following:

1. Acknowledges that Dawn Quioko/Buff Mama, is not a physician and is not trained in any way to provide medical diagnosis, medical treatment, or any other type of medical advice.
2. Acknowledges that coaching/training is another tool for teaching athletes/individuals about themselves, but that Dawn Quioko/Buff Mama, does not guarantee neither good nor bad will occur nor guarantees the training advice given by Dawn Quioko/Buff Mama will produce good nor bad results.
3. Acknowledges that the undersigned has been told if they feel tired, feel pain or feel out of the ordinary in any way either related to your training, or otherwise, that the undersigned should contact a physician at once.
4. Acknowledges that boot camps, aerobic classes, martial arts, kick boxing, running, kung-fu, weight training, obstacle courses, and any other related sports are an extreme test of one's mental and physical limits and carry with it potential for damage or loss of property, serious injury and death. That the undersigned assumes the risks of participating in these types of events/activities including the elements of a natural environment, that they are fit, and they have a regular medical physician they can contact regarding any medical problems that they might develop. The undersigned expressly waive, release, discharge and agree not to sue from any liability of death, disability, personal injury, or action of any kind Dawn Quioko/Buff Mama Inc. for the undersigned participating in said sporting events and/or training for said sporting events.

The Undersigned agrees that this is the full agreement between the parties, that Dawn Quioko/Buff Mama nor anyone else has not verbally contradicted any of the terms of this release and that the undersigned has entered into this agreement free and voluntarily without force or coercion. I,

 Signature

 Date

 Printed Name