Barrie Community Health Centre

Fitness for Health
Participant Registration Form

Date:

Name:

Address:

Home Phone: | **Cell Phone:**

Email:

Date of Birth: | **Age:** | **Health Card #**

Emergency Contact Name: asdfasdfasdfasdfasfasdfasdfas

Relationship: | **Phone:**

Family Physician/ Nurse Practitioner: | **Phone:**

How did you hear about this Program?

What is your goal for the Program?

Completed by: _____ _____

Print name | Signature