Wings Membership Application

Wings is a community-based program designed to promote the importance and awareness of regular physical activity, health education, and nutrition for a healthier lifestyle. This program is free and open to the public. You must reside in the Cherokee Nation service area to be a member.

What Cherokee Nation Public Health provides for you...
• Provide free registration walk/runs throughout the year
• Currently providing 12 in-person races opportunities. Each race offers a virtual option to participate.

What you as a Wings Member will provide for us...
• Attend (the walk/runs throughout the year. You must pre-register for each race. Cherokee Nation Public Health (CNPH) does not accept any race day registration. CNPH also keeps track of race attendance. If you miss 3 races (that you signed up for) throughout the calendar year (January-December), you will forfeit your race privileges for the next 12 months. You become “inactive” by not attending a race for 6 months consecutively. At the point of “inactive” you must provide updated contact information if anything has changed and if your health has changed, you must submit a new Wings application along with a letter from your doctor clearing you to participate in physical activity (see page 4 of this application).

***Important:*** You must be accepted as a Wings member before you can start entering the Wings sponsored runs. Please allow up to two weeks for processing Wings application. Please do not submit a race form with your Wings application. Thank you.

Wings Program Contacts:
Trina Jackson trina-jackson@cherokee.org
Phone: 918-207-3913

Jeff Tucker jeff-tucker@cherokee.org
Phone: 918-453-5000 Ext: 7070

For the latest Wings race schedule, visit:
https://www.cherokeepublichealth.org/tiles/index/display?alias=Wings
REQUIRED FORM - Must Complete and Return

INFORMED CONSENT

Please print legibly

Name: ____________________________________________________________

Mailing Address: ___________________________________________________

(Town) __________________ (County) __________________ (Zip) _________

Age: _____ Date of Birth: __________ E-mail: ____________________ ☐ Male ☐ Female

(Parents e-mail, if applicant is under age 18)

Student: ☐ Yes ☐ No School: ___________________________ American Indian/Alaskan Native: ☐ Yes ☐ No

Tribal Affiliation(s): ___________________________________________ T-shirt size: ________ Veteran: ☐ Yes ☐ No

Home # ___________________ Cell # ___________________ Work# ___________________

I understand that my participation with Wings involves physical exercise that may be strenuous at times. This activity involves risks and injuries that may occur during my physical fitness activity. I understand and agree that I should be in adequate physical condition or acquire a recommended physician clearance before engaging in this fitness and exercise program.

In the event of illness, injury or accident during my fitness participation as a member of Wings, I or my parent/guardian if I am a minor child, hereby release, hold harmless, discharge and agree not to sue the Cherokee Nation, partner school systems and organizations, their employees or representatives, and owners/lessors of premises from all liabilities or damages brought in litigation by other persons or parties on behalf of participants. This includes, but is not limited to liability of illness, injury or accident, lost, stolen or damaged property, or other risks that are not foreseeable which may occur during my participation. If illness, injury or accident occurs requiring immediate medical attention, I or my parent/guardian, if I am a minor, authorized sponsoring representatives to obtain necessary medical treatment for my condition.

I have read this form and understand that there are inherent risks associated with any physical activity and recognize it is my responsibility to provide accurate and complete health/medical history information. Furthermore, it is my responsibility to monitor my individual physical performance during any activity.

_________________________________________ ________________
Signature  Date

Parent/Guardian Signature
( Must be signed by parent or guardian if child is under 18 years of age)

_________________________________________ ________________
Signature  Date

Parent/Guardian Signature
( Must be signed by parent or guardian if child is under 18 years of age)

NOTICE OF HEALTH INFORMATION PRACTICES

Cherokee Nation Healthy Nation Wings Fitness Program

I have been provided an opportunity to review and have a copy of the Notice of Health Information Practices of the Cherokee Nation Health Services. (Please read pages 5 & 6 in this application)

_________________________________________ ________________
Signature  Date

Parent/Guardian Signature
( Must be signed by parent or guardian if child is under 18 years of age)

_________________________________________ ________________
Signature  Date

Parent/Guardian Signature
( Must be signed by parent or guardian if child is under 18 years of age)
REQUIRED FORM - Complete and Return
PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)

Name____________________________________________________________________

What is a Par-Q? The Par-Q is a simple screening tool and necessary before beginning this exercise program. The purpose is to clear for exercise or refer for further screening. The objective is not diagnostic, but to determine risk: orthopedic, cardiovascular and chronological.

YES    NO Please read each question carefully and check the appropriate answer.

☐ ☐ 1) Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?

☐ ☐ 2) Do you feel pain in your chest when you do physical activity?

☐ ☐ 3) In the past month, have you had chest pain when you were not doing physical activity?

☐ ☐ 4) Do you lose your balance because of dizziness or do you ever lose consciousness?

☐ ☐ 5) Do you have a bone or joint problem that could be made worse by a change in your physical activity?

☐ ☐ 6) Is your doctor currently prescribing medication for your blood pressure or heart condition?

☐ ☐ 7) Do you have insulin dependent diabetes?

☐ ☐ 8) Do you know of any other reason why you should not engage in physical activity?

If you answered “Yes” to one or more questions, you MUST complete a physical examination with physician consultation i.e. LETTER TO PHYSICIAN before becoming more physically active.

If you answered “No” to all questions, you have reasonable assurance that you can safely increase your level of physical activity on a gradual basis. A physical examination is not required.

I have read, understood and completed this Par-Q form. I am aware that there are inherent risks associated with any physical activity and recognize that it is my responsibility to provide accurate health and medical history information.

_________________________________________  _____________________
Signature  Date

Parent/Guardian Signature  Date
(Must be signed by parent or guardian if child is under 18 years of age)

PHOTO/MEDIA INFORMATION
Wings races are public events; be aware that sound recordings, photographs and video devices may be present.
Dear Physician:

Your patient ________________________________________________ wishes to become a member of the Wings Physical Activity Program. This self-paced program involves progressive resistance training, flexibility exercises, and a cardiovascular routine, increasing in duration and intensity over time.

After completing a Physical Activity Readiness Questionnaire (PAR-Q) and identifying a medical condition, we agree to seek your advice before participation in this physical activity program.

A physical examination is required, so please make recommendations or restrictions that are appropriate for your patient.

Thank you.

Please check one of the following that apply.

☐ I am not aware of any contradictions toward applicant participation in this physical activity program.

☐ The application should not engage in the following activities:

_________________________________________________________________________

☐ I recommend the applicant not participate in this physical activity program.

Physician Signature: ___________________________________________ Date: _____________________

Physician Name (print): __________________________________________

Clinic/Hospital Name: __________________________________________

Address: _____________________________________________________

Phone #: ______________________________________________________