University of CINCINNATI | CAMPUS RECREATION

Training & Nutrition Registration

Step 1: Mark your status **Step 2:** Select your service(s) and package(s) **Step 3:** Complete all forms

MEMBER STATUS (please check all that apply)

☐ Student ☐ Non-Student ☐ Member ☐ Non-Member

SERVICES (please check your service and then select your package)

		PACKAGES
☐ **Personal Training:**		3 5 10 20
☐ **Buddy Training:**	(groups of 2) Name of training partner: _____	5 10 20
☐ **Nutrition Coaching:**	Resting Metabolic Measurement Only / Grocery Store Tour / Follow Up	3 5 10
☐ **Total Wellness Package:**	(personal training with 2 nutrition coaching sessions, includes RMR)	10

REFERRAL PROGRAM

Were you referred by an active* training client? ☐ Yes ☐ No

Please tell us who, below. **You and your friend** will each receive **1 FREE training session** with your initial** purchase of 5+ session packages.

_____

CONTACT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Primary Phone Number: _____ Email: _____

Address: _____
STREET CITY

_____
STATE ZIP

Emergency Contact: _____ Emergency Contact Phone: _____

Physician: _____ Physician Phone: _____

TRAINING INFORMATION

Trainer Preference: MALE / FEMALE (please circle)

Request trainer by name: _____

Summary of fitness/health goals: _____

_____

Notable health issues: _____

How did you hear about our program: _____

Please list your availability:

DAY	TIME(S)
Mon	_____
Tues	_____
Wed	_____
Thurs	_____
Fri	_____
Sat	_____
Sun	_____

* ACTIVE clients: have an open training package with sessions remaining
** INITIAL: first training purchase within the last year

PAR-Q+

University of CINCINNATI | CAMPUS RECREATION

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor, **OR** a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
1) Has your doctor ever said that you have a heart condition, **OR** high blood pressure?		
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?		
3) Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? *Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise).*		
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** _____		
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** _____		
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer NO if you had a problem in the past, but it does not limit your current ability to be physically active. **PLEASE LIST CONDITION(S) HERE:** _____		
7) Has your doctor ever said that you should only do medically supervised physical activity?		

✓ **If you answered NO to all of the questions above, you are cleared for physical activity.**
Go to Page 6 to sign the PARTICIPANT DECLARATION. You do not need to complete Pages 3, 4 and 5.

- **Start becoming much more physically active - start slow and build up gradually.**
- **You may take part in a health and fitness appraisal.**
- **If you are over the age of 45 yr. and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.**

● **If you answered YES to one or more of the questions above, COMPLETE PAGES 3, 4 AND 5.**

▲ **Delay becoming more active if:**

- **You have a temporary illness such as a cold or fever; it is best to wait until you feel better.**
- **You are pregnant - talk to your healthcare practitioner, your physician, and/or a qualified exercise professional before becoming more physically active.**
- **Your health changes - answer the questions on Pages 3, 4 and 5 of this document, and/or talk to your doctor, or a qualified exercise professional before continuing with any physical activity program.**

PAR-Q+

University of CINCINNATI | CAMPUS RECREATION

Follow-up Questions About Your Medical Question(s)

1. Do you have Arthritis, Osteoporosis, or Back Problems?

If the above condition(s) is/ are present, answer questions 1a-1c

If **NO** go to question 2

1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES**	**NO**
1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/parsdefect (a crack in the bony ring on back of the spinal column)?	**YES**	**NO**
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	**YES**	**NO**

2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a-2b

If **NO** go to question 3

2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?	**YES**	**NO**
2b.	Are you currently receiving cancer therapy (such as chemotheraphy or radiotherapy)?	**YES**	**NO**

3. Do you have a Heart or Cardiovascular Condition?

This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm

If the above condition(s) is/are present, answer questions 3a-3d

If **NO** go to question 4

3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES**	**NO**
3b.	Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)	**YES**	**NO**
3c.	Do you have chronic heart failure?	**YES**	**NO**
3d.	Do you have diagnosed coronary artery (cardiovascular) disease, and have not participated in regular physical activity in the last 2 months?	**YES**	**NO**

4. Do you have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b

If **NO** go to question 5

4a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES**	**NO**
4b.	Do you have a resting blood pressure equal to, or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure)	**YES**	**NO**

Follow-up Questions About Your Medical Question(s)

5. Do you have any Metabolic Conditions?

This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes

If the above condition(s) is/ are present, answer questions 5a -5e

If **NO** go to question 6

5a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer NO if you are not currently taking medications or other treatments)	**YES**	**NO**
5b.	Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.	**YES**	**NO**
5c.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, OR the sensation in your toes and feet?	**YES**	**NO**
5d.	Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?	**YES**	**NO**
5e.	Are you planning to engage in an activity that for you is unusually high (or vigorous) intensity exercise in the near future?	**YES**	**NO**

6. Do you have any Mental Health Problems or Learning Difficulties?

This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome

If the above condition(s)is/are present, answer questions 6a-6b

If **NO** go to question 7

6a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES**	**NO**
6b.	Do you have Down Syndrome **AND** back problems affecting nerves or muscles?	**YES**	**NO**

7. Do you have a Respiratory Disease?

This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure

If the above condition(s) is/are present, answer questions 7a-7d

If **NO** go to question 8

7a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES**	**NO**
7b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	**YES**	**NO**
7c.	If asthmatic, do you currently have symptoms of chest tightness, wheezing, labored breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	**YES**	**NO**
7d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	**YES**	**NO**

Follow-up Questions About Your Medical Question(s)

8. Do you have a Spinal Cord Injury?

This includes Tetraplegia and Paraplegia

If the above condition(s) is/ are present, answer questions 8a-8c

If **NO** go to question 9

8a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES**	**NO**
8b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light -headedness, and/or fainting?	**YES**	**NO**
8c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	**YES**	**NO**

9. Have you had a Stroke?

This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event

If the above condition(s)is/ are present, answer questions 9a-9c

If **NO** go to question 10

9a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	**YES**	**NO**
9b.	Do you have any impairment in walking or mobility?	**YES**	**NO**
9c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	**YES**	**NO**

10. Do you have any other medical condition not listed above, or do you have two or more medical conditions?

If you have other medical conditions, answer questions 10a-10c

If **NO** read the Page 4 recommendations

10a.	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months, **OR** have you had a diagnosed concussion within the last 12 months?	**YES**	**NO**
10b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	**YES**	**NO**
10c.	Do you currently live with two or more medical conditions?		

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE: _____

_____

_____

_____

GO to Page 6 for recommendations about your current medical condition(s), and sign the PARTICIPANT DECLARATION.

PAR-Q+

University of CINCINNATI | CAMPUS RECREATION

The Physical Activity Readiness Questionnaire for Everyone

✓ **If you answered NO to all of the follow-up questions about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:**

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and buildup gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 yr. and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise

If you answered **YES** to **one or more of the follow-up questions** about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal.

Delay becoming more active if:

- You have a temporary illness such as cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your healthcare practitioner, your physician, and/or a qualified excercise professional before becoming more physically active.
- Your health changes - talk to your doctor or qualified exercise professional before continuing with any physical activity program.

- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed -X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that a Trustee (such as my employer, community/fitness center, healthcare provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national and international guidelines regarding the storage of personal health information ensuring that the Trustee maintains the privacy of the information and does not misuse or wrongfully disclose such information.

NAME _____ **DATE** _____

SIGNATURE _____ **WITNESS** _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

The PAR-Q was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E.R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services.

WELLNESS SERVICES CONTRACT

I, _____, have enrolled to participate in University of Cincinnati Campus Recreation Wellness Services and/or Programs.

Please initial in the box at the left to indicate you understand each statement. I fully understand that:

_____ The below forms must be completed in full and signed prior to beginning sessions. It is my responsibility to notify my CRC staff member of any change in my health status.
CRC Release of Liability and Consent
Health History Questionnaire (PAR-Q +)
Medical Consultation (if applicable)

_____ Once a CRC staff member is identified for my needs, I am responsible for scheduling my session(s).

_____ I should be dressed and ready to begin at the scheduled start time. Session will end at the scheduled end time regardless of start time.

_____ (Individual Pkg.) If I am unable to make the scheduled session due to illness, emergency, travel or any other circumstance, it is my responsibility to notify my CRC staff member 24 hours in advance and reschedule my appointment.

_____ I will be charged in full for a session if less than 24-hour notification is given.

_____ Payment can be made by cash, credit/debit card, Bearcat Card or check made payable to the University of Cincinnati.

_____ Payment must be made prior to scheduled session.

_____ Payment is non-refundable.

_____ All sessions expire six (6) months from the purchase date and are non-transferrable.

_____ (Buddy Training) If either party is unable to make the scheduled session due to illness, emergency, travel or any other circumstance, it is our responsibility to notify our personal trainer 24 hours in advance and reschedule the appointment. Or, the session may still be delivered to one person at the Buddy Training rate; however, clients absent from this session will forfeit the session.

_____ I will notify my CRC staff member of any medications or health conditions that may affect my ability to perform physical activity or worsen by becoming physically active.

I have read the above and agree to abide by University of Cincinnati Campus Recreation policies and procedures presented in this contract.

_____ _____

Client Signature Date

_____ _____

CRC Staff Signature Date

RELEASE OF LIABILITY

University of Cincinnati Campus Recreation Center
RELEASE OF LIABILITY AND CONSENT — Wellness Services

• In consideration of the opportunity to receive and participate in University of Cincinnati Campus Recreation ("CRC's") Fitness/Wellness programs, I hereby assume all risks of injury, illness, death or other loss arising from or in any way relating to my participation in such programs and receipt of related services.

• I hereby release, agree not to sue, and forever discharge University of Cincinnati and CRC and their respective Affiliates* (as defined below) of and from any and all manner of claims, demands, actions, causes of action, liability, damages, claims for punitive or liquidated damages, claims for attorney's fees, costs and disbursements, individual or class action claims, and demands of any kind whatsoever, I have or might have against them or any of them, whether known or unknown, in law or equity, contract or tort, arising out of or in any way relating to my participation in CRC programs, use of Campus Recreation and loss of personal property, however originating or existing. This release shall be binding upon my heirs, personal representatives, administrators, executors, and assigns.

• I understand that this release includes, without limitation, all injuries which may occur as a result of the following: (a) my use of CRC's amenities and equipment in CRC facilities, my receipt of instruction and other services from CRC (including, without limitation, massage therapy services) or my participation in any activity, class, program, training or instruction; (b) the malfunctioning of any equipment; (c) CRC's training, supervision, or dietary recommendations; and (d) my slipping and/or falling while in or on CRC's premises, including adjacent sidewalks and parking areas.

• I further understand that any recommendations regarding exercise or diet (including, without limitation, the use of supplements) are entirely my responsibility and that I should consult a physician prior to undergoing any changes in exercise or diet.
I understand that training programs (including related fitness assessments) and massage therapy sessions are not intended to replace any medical screening I may need, and the CRC, nor any of their respective Affiliates, will determine whether an exercise program or dietary change are medically appropriate for me. I understand it is my responsibility to consult with my physician regarding these matters.

• I further understand CRC staff will question me about my health status, and I agree to complete a health history questionnaire. I certify the information I provide to CRC staff about my health and exercise history and current health status will be, to the best of my knowledge, complete and accurate, and I agree and understand it is my responsibility to inform CRC staff in the event of any change in my health or medical status. CRC shall treat information regarding my personal health and medical status as confidential. CRC shall not release such information without my written consent, except: to authorized CRC and employees, agents, successors, and assigned contractors who we use to support our business; in connection with any programs sponsored by my employer in which I participate; in connection with the sale, assignment, or other transfer of the business which the information relates; when applicable by laws, court orders or government regulations require us to do so; and to health care personnel for treatment purposes (including, for example, emergency assistance personnel). I understand that CRC may use or disclose to others information regarding my health for statistical analysis or other research purposes, provided that my name and other personally identifiable information will be removed from the information prior to such uses and disclosures.

• I fully understand that I have enrolled in a program that may include strenuous physical activity including, but not limited to muscular flexibility enhancement, aerobic exercise, and resistance training through the use of various facilities and exercise equipment. I understand there are possibilities of injury or other complications, including but not limited to musculoskeletal injuries, cardiovascular trauma, neurological impairment, heart attack and even death, which may occur during fitness assessment, while completing an exercise program, while otherwise using CENTER facilities, or while participating in any health and fitness program activities.

• I understand it is my responsibility to consult with my physician regarding my training program participation, and realize it is generally recommended that all adults consult with a physician before starting a physical activity program. I understand that my CRC staff member may, based on a review of my application and health history form, require that I consult with and obtain recommendations from a physician before participating in the first session. I understand I may obtain from my CRC staff member a "Medical Consultation" form on which my physician's recommendations can be documented, and will be submitted to my CRC staff member before my first session. I acknowledge and agree that if I do not accurately and completely communicate my physician's recommendations to my personal trainer, I take full and entire responsibility for that decision and for any outcomes related to that decision.

• I understand use of the CRC and participation in a fitness assessment, health and fitness program activities is strictly voluntary, is not required of employees of participating companies, and I may discontinue my participation at any time. I further understand CRC may revoke my privileges to use CRC or otherwise participate in assessment or other programs at any time, in its sole discretion. I agree to be bound by and obey all the rules and policies of the CRC and CRC staff in my use of the CRC and in my participation in the health and fitness program activities.

• I understand at any time I may review this Release of Liability and Consent by requesting a copy from CRC staff. I agree if any portion of this form is held invalid, the remainder of this form will continue in full legal force and effect.

• I have carefully read this Release of Liability and Consent and fully understand its terms. I sign it voluntarily with full knowledge of its legal significance and understand that I have the right to have my attorney review it.

Signature (if under 18, legal guardian) *Date*

Print Name *Date*

**"Affiliates" means any branch, division, or subsidiary of CRC, or CRC's present and former officers, directors, shareholders, trustees, employees, agents, representatives, contractors, and the successors and assigns of each, whether in their individual or official capacities.*