AUBURN®

CAMPUS RECREATION

PERSONAL TRAINING

Welcome

Welcome and thank you for your interest in personal training at Auburn University. You have taken the first step towards better overall health! We thank you for allowing our Campus Recreation Personal Training team to be your guide. Our staff is dedicated to helping you reach your goals by promoting healthy, lifelong fitness behaviors! Before you can get started with your new personal trainer, please read this packet in its entirety and fill out all applicable forms. These forms are an important means for us to help you reach your goals safely and effectively. Congratulations on taking the next step to achieving a healthier you!

Program policies & procedures

Payment policy: Campus Recreation charges a fee for services rendered by personal trainers. All services can be purchased anytime throughout the year at the Campus Recreation main office located on the 3rd floor in the Recreation and Wellness Center, at the Personal Training welcome desk, or via Auburn University Online Payment Portal. Payment must be received before you will be scheduled for an assessment and/or session. Paying a personal trainer directly is strictly prohibited.

Expiration policy: All personal training packages expire 120 days from the date of purchase. Personal training sessions are void after this time period. All personal training packages are non-refundable (see refund policy) and non-transferable.

Refund policy: Campus Recreation does not issue refunds (full or partial) for memberships, group fitness passes, personal training sessions, or any other for-fee service or program.

Late policy: If you arrive more than 15 minutes late for the scheduled appointment, forfeiture of the session will result and the personal trainer has the right to leave the premises. All sessions are scheduled for 60 minutes and will end one hour from the scheduled start time.

Cancellation policy: If you must cancel or reschedule a training session, please notify your personal trainer by phone, text, and/or email at least 24 hours in advance of the scheduled training session. Personal training sessions that are not rescheduled or canceled at least 24 hours in advance by the client will result in forfeiture of the session.

Semi-Private Training Cancellation Policy: If one client cancels within 24 hours of a scheduled semi-private session or simply does not show, the session may continue with the remaining client(s). The session will still count toward the package balance for each of the clients.

Registration policy: The completed personal training registration packet (along with payment) must be received before you will be scheduled with a certified personal trainer. The completed registration packet can be returned either by email or at the Campus Recreation Personal Training welcome desk. Upon receipt of these materials, a member of our staff will contact you via email and/or phone within 72 hours to schedule your initial appointment.

****Please retain this page for your records****

AUBURN UNIVERSITY PERSONAL TRAINING REGISTRATION FORM

Name: _____ Date: _____

E-Mail Address: _____ Phone Number: _____

Auburn Affiliation: ☐ STUDENT ☐ FACULTY/STAFF ☐ SPOUSE/ PARTNER ☐ RETIREE BANNER ID ☐

Desired number of personal training sessions per week: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

**It is recommended that all participants work with their personal trainer at least 2-3 times per week.*

Do you prefer a male or female trainer? ☐ Male ☐ Female ☐ No Preference

Specific Trainer requested? _____

We will make every effort to accommodate requests, but they cannot be guaranteed. Assignments are based on client goals, fitness levels, and schedules.

Please choose which days you are available to train: (Check all that apply)

☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday** ☐ **Saturday** ☐ **Sunday**

Please choose which blocks of time you are available to train: (Check all that apply)

☐ **5:30 - 8 a.m.** ☐ **8 - 11 a.m.** ☐ **11 a.m. - 2 p.m.** ☐ **2 - 5 p.m.** ☐ **5 - 8 p.m.**

Select the package and number of sessions you would like to purchase:

☐ One-On-One Personal Training ☐ 1 ☐ 3 ☐ 6 ☐ 9 ☐ 12 ☐ 18 ☐ 24

☐ Semi-Private Personal Training (2-3 people) ☐ 1 ☐ 3 ☐ 6 ☐ 9 ☐ 12 ☐ 18 ☐ 24

☐ Small Group Training (4-8 People)

How did you hear about Personal Training?

Training With (if purchasing Semi-Private or Small Group Training):

_____ _____ _____ _____ _____

Please purchase Semi-Private packages once your group is set. We do not pair individuals for Semi-Private training.

By signing below I verify that I have read and understand the PROGRAM POLICIES AND PROCEDURES form received with this Personal Training Packet.

_____ _____

Signature *Date*

Medical Health History Questionnaire

This form is not a substitute for a thorough physical examination, assessment, and/or diagnosis by your physician. It is designed to identify and understand potential issues that may arise due to an increase in physical activity. The Auburn University Campus Recreation Fitness team strongly recommends that each client undergo a medical examination before beginning any exercise program. All information provided on this form is personal and confidential and will not be released to anyone except your referring physician without your written consent. The information you provide will enable us to better understand you and your health and fitness habits.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ @auburn.edu Phone Number: _____

Date of Birth: _____ Age: _____ Gender: _____ Height: _____ Weight: _____

Auburn Affiliation: ☐ Faculty/Staff ☐ Student ☐ Fr ☐ So ☐ Jr ☐ Sr ☐ Grad ☐ Retiree ☐ Spouse/Partner

PhysiciansName: _____ Phone Number: _____

Emergencycontact: _____ Relationship: _____

Home phone: _____ Cell Phone: _____

I. Personal Fitness Goals & Exercise History

1. Please indicate your personal health and fitness goals: (check all that apply)

☐ Reduce Body Fat & Lose Weight	☐ Weight Gain	☐ Better Balance & Mobility
☐ Increased Confidence & Energy	☐ Improve Stamina & Flexibility	☐ Improve Nutrition
☐ Build Lean Muscle Mass	☐ Muscular Strength	☐ Improve Cardiovascular
☐ General Health & Fitness	☐ Reduce Blood Pressure/Cholesterol	☐ Fitness Reshape Body
☐ Enhance work, recreation & sports performance	Other: ☐ _____	

Please tell us more about your specific short and long term goals for exercise, health, and fitness:

2. Exercise history	Yes	No
Do you currently exercise? If yes, how many times per week? _____	☐	☐
If no, have you exercised in the past?	☐	☐
Have you ever worked with a fitness professional before?	☐	☐

If you currently exercise, what exercise activities does your workout program include?

II. Signs and symptoms

3. Have you ever experienced any of the following: (check all that apply)

- ☐ Pain, discomfort, tightness or numbness in the chest, neck, jaw or arms
- ☐ Shortness of breath at rest or with mild exertion
- ☐ Difficult, labored or painful breathing during the day or night
- ☐ Unusual shortness of breath or fatigue with usual activities
- ☐ Heart murmur and/or palpitations
- ☐ Severe headaches
- ☐ Dizziness or Fainting
- ☐ Ankle Swelling
- ☐ Rapid pulse or heart rate
- ☐ Claudication (Cramping)
- ☐ Back Pain
- ☐ Orthopedic problems

If you checked any of the above conditions, you must explain below:

III. Medical diagnoses

4. Have you ever been diagnosed with, or suffered from: (check all that apply)

- ☐ Heart attack/heart disease
- ☐ Coronary bypass
- ☐ Stroke
- ☐ Aneurysm
- ☐ Angioplasty
- ☐ Other Cardiac Surgery
- ☐ Pacemaker
- ☐ Embolism
- ☐ Angina Pectoris
- ☐ Phlebitis

If you checked any of the above conditions, you must have **medical clearance** prior to exercising.
Please give details:

5. Have you ever been diagnosed with, or do you have any of the following: (check all that apply)

- ☐ Chronic bronchitis
- ☐ Diabetes
- ☐ Osteopenia
- ☐ Asthma
- ☐ Thyroid problems
- ☐ Emotional disorders
- ☐ Cancer
- ☐ Peripheral vascular disease
- ☐ Osteoporosis
- ☐ Emphysema
- ☐ Hypertension (>140/90 mmhg)
- ☐ High cholesterol (>200 mg/dl)
- ☐ Eating disorders
- ☐ Swelling of joints

If you checked any of the above conditions, please explain below:

IV. Major risk factors

6. Please answer all of the following questions:	Yes	No	Unsure
Are you a male over the age of 45 or female over the age of 55 who has had a hysterectomy or is postmenopausal?	☐	☐	☐
Has your father or brother experienced a heart attack before age of 55?	☐	☐	☐
Has your mother or sister experience a heart attack before age of 65?	☐	☐	☐
Do you have impaired fasting glucose (diabetes)?	☐	☐	☐
If yes, do you take insulin? What year was the diagnosis? _____			
Do you have high cholesterol (>200ml/dl)?	☐	☐	☐
Has your doctor ever told you that you might have high blood pressure?	☐	☐	☐
Do you currently smoke or have you smoked in the past 6 months?	☐	☐	☐
Do you have a sedentary lifestyle?	☐	☐	☐

If you are a man over the age of 45 or a woman over the age of 55 or if you answered "yes" to two (2) or more of the above major risk factors, it is recommended that you receive a ***physician's clearance*** *before beginning your exercise program. Please feel free to provide additional information below.*

V. General

7. Please tell us more about you:	Yes	No
Are you currently pregnant?	☐	☐
Are you currently on a special diet?	☐	☐
Have you had a recent surgery in the past 12 months?	☐	☐
Do you have allergies? If "yes" please provide any information below.	☐	☐
Do you take ergogenic aids, diet supplements, vitamins, minerals, etc.?	☐	☐

8. Please list any medications you are currently taking including but not limited to prescriptions, allergy medications, vitamins, supplements, etc.

Medication(supplement):_____ Reason:_____ Dosage:_____

Medication(supplement):_____ Reason:_____ Dosage:_____

Medication(supplement):_____ Reason:_____ Dosage:_____

Medication(supplement):_____ Reason:_____ Dosage:_____

List any other information you would like your trainer to know:

I understand this medical health history questionnaire has been provided for the purpose of helping me better understand any potential risks associated with a workout program. I also understand I should share this information with my physician and seek his or her approval prior to beginning an exercise program. I understand the information I have provided will be maintained in my personal file for use in case of a medical emergency. My signature signifies that all of the above is true, to the best of my knowledge. Any information left unanswered was done so intentionally. If any of the above information changes, I agree to submit these changes in writing to the personal training department.

Participant signature: _____ Date: _____

Fitness staff signature: _____ Date: _____

Staff Use Only Classification: ☐ Low Risk ☐ Moderate Risk ☐ High Risk

Comments: _____

_____

_____

2020 PAR-Q+

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.
Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow Global Physical Activity Guidelines for your age (https://apps.who.int/iris/handle/10665/44399).
- 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 have any further questions, contact a qualified exercise professional.

PARTICIPANT DECLARATION

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 the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

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 health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

01-11-2019

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FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(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/pars defect (a crack in the bony ring on the 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 currently 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 ☐

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 often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?	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 what for you is unusually high (or vigorous) intensity exercise in the near future?	YES ☐ NO ☐

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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, laboured 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 ☐

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?	YES ☐ NO ☐

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

_____

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

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If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) 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 build up 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. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+ at www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

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 health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ **at www.eparmedx.com** before becoming more physically active.
- Your health changes - talk to your doctor or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- 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 the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact
www.eparmedx.com
Email: eparmedx@gmail.com

Citation for PAR-Q+
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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. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

Key References

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

11-01-2019

Informed consent for participation

1) Objective of the Fitness Assessment

In order to permit the Auburn University Recreation Personal Training staff to design an exercise program appropriate for my current level of fitness, I hereby consent, voluntarily, to a fitness assessment. I understand that the tests that will be administered to me are for the purpose of determining my physical fitness status, and may include the measurement of my body composition, cardiorespiratory endurance, muscular endurance, muscular strength, flexibility, and functional movement.

2) Explanation of the Assessment

Body Composition Assessment

Based on your specific goals, you may perform one or more of the following tests to determine your body composition. The Tanita Scale involves the use of Bioelectrical Impedance Analysis to determine your percentage of body fat. Circumference measurements are used to determine the girth of body segments.

Cardiorespiratory Endurance Assessment

You will perform a 3-Minute Step Test to measure your cardiovascular fitness level. This test is on a 12-inch box step with a metronome set to 96 beats per minute. You will step up on the box step to the metronome beat for three consecutive minutes. When three minutes are up, stop immediately, sit down, and the trainer will count your pulse (using your wrist) for one full minute.

Muscular Strength and Endurance Assessment

Based on your specific goals, you may perform one or more of the following tests to determine your muscular strength and/or endurance. The push-up test is a maximum repetition assessment. The curl-up is a one minute time limit test based on a metronome cadence of 50 beats per minute. The hand dynamometer will be used to measure hand grip strength.

Flexibility Assessment

You will perform a sit and reach test to assess the flexibility of your hamstrings and lower back muscles.

Functional Movement Screen

The FMS is used to identify asymmetries which result in functional movement deficiencies. The FMS aims to identify imbalances and mobility and stability during seven fundamental movement patterns.

Nutrition Assessment

You will have the option to submit a 3-day dietary recall for analysis. A Registered Dietitian and dietetic interns will make recommendations based on that analysis.

3) Description of Potential Risks and Discomforts

There exists the possibility of certain changes occurring during the fitness assessment. They include abnormal blood pressure, fainting, irregular, fast or slow heart rhythm, and in rare instances, heart attack, stroke, or death.
Depending upon your level of conditioning you can expect some post exercise muscle soreness. Every effort will be made to minimize these risks by evaluation of preliminary information relating to your health and fitness and by observations during the assessment. Emergency procedures and trained personnel are available to deal with unusual situations that may arise.

4) Responsibilities of the Participant

Information that you possess about your health status or previous experiences of unusual feelings with physical effort may affect the safety and value of your fitness assessment. Your prompt reporting of feelings with effort during the assessment itself is also of great importance. You are responsible for fully disclosing such information when requested by the staff members performing the assessment.

5) Benefits to be Expected

The results obtained from the fitness assessment may assist in evaluating the type of physical activity you might do with low risk. It will also provide baseline data with which to compare future assessment results to determine the effectiveness of your fitness program.

I have read this form, and I understand the procedures that I will perform, assumed risks, and dis-comforts. Knowing these risks and discomforts, and having had an opportunity to ask questions that have been answered to my satisfaction, I consent to participate in this activity.

Participant Signature _____ Date _____

Parent/Guardian
(if participant is under 19 years of age) _____ Date _____

Release and waiver of liability and indemnity agreement

In consideration of being permitted to participate in a fitness assessment, fitness programs, and/or personal training sessions, which may consist of warm-up, flexibility activities, cardiorespiratory endurance activities, muscular strength and endurance activities, body composition assessments, nutrition assessment, nutrition analysis, and/or nutrition consultation provided by the Personal Training program at the Auburn University Recreation and Wellness Center.

I, _____, the undersigned:

1) Hereby releases, waives, discharges and covenants not to sue Auburn University, its board of trustees, officers, employees, agents, promoters, other participants, operators, trainers, sponsors and advertisers involved in said fitness assessment, fitness program, and/or personal training sessions, all for the purposes herein referred to as “releasee”, from all liability to the undersigned, his/her personal representatives, assigns, heirs and next of kin for any and all loss or damage, and any claim or demands therefore on account of injury to the person or property or resulting in death of the undersigned, whether caused by the negligence of the releasee or otherwise while the undersigned is participating in any or all of the aforementioned activities.

2) Hereby agrees to indemnify and save and hold harmless the release and each of them from any loss, liability, damage, or cost they may incur due to the presence of the undersigned in or upon any area or in any way participating in the aforementioned activities whether caused by the releasee or otherwise.

3) Hereby assumes full responsibility for and risk of bodily injury, death or property damage due to the negligence of releasee or otherwise while in or upon the facilities of Auburn University and while participating in any aforementioned activity.

4) I understand that I must have individual health insurance equal to or greater than the insurance offered by the Auburn University student government association, to participate in Auburn University health/wellness/fitness programs.

5) I expressly acknowledge and agree that the activities could be dangerous and involve risk of serious injury and/or death. I further expressly agree that the foregoing release, waiver, and indemnity agreement is intended to be as broad and inclusive as is permitted by law of the province or state in which the event is conducted and that if any portion thereof is held invalid, it is agreed that the balance shall, not withstanding, continue in full legal force and effect. The undersigned has read and voluntarily signs the release and waiver of liability and indemnity agreement, and further agrees that no oral representations, statement or inducement apart from the foregoing written agreement have been made. By signing this document, I hereby acknowledge that I am at least 19 years of age and have read the above carefully before signing, and agree with all of its provisions this

_____ Day of _____, 20___.

Participant signature

_____

Parent/Guardian (if participant is under 19 years of age)

_____

Signature of witness (fitness staff)

_____