



PARKER
C O L O R A D O

Parks and Recreation

For office use:

Amount: _____

Date: _____

Attach register receipt
to front of form

2018 Commit to Fit Weight Loss Challenge Client Registration

-Confidential-



Personal Training and Private Instruction Information

Please Read Carefully

Personal Training and Private Instruction Policies

In order to help make your experience a positive one, we ask that you observe the following policies:

1. Client Registration Packet must be completed prior to first session or during first session. It is recommended to complete in advance.
2. New clients must purchase sessions prior to the first scheduled session.
3. Trainers cannot take session payments. Please pay for sessions at the Recreation Center or Fieldhouse front desk.
4. Call the Recreation Center or Fieldhouse (where your scheduled session will take place) if you know you will be late (Trainers will wait 15 minutes and then that scheduled session will be forfeited). If you are late, the session will only last until the end of the hour for which that session was scheduled.
5. If needed, sessions must be rescheduled 24 hour in advance or session will be forfeited. Call your Trainer directly to reschedule your appointment.

Client Confidentiality

Information will not be released without the individual's permission, except in emergency situations.

Regular evaluation of your Trainer's performance and your progress will be completed using written and verbal communication with your Trainer and our fitness staff. If you have any feedback regarding your Trainer or the program, please contact the Fitness and Wellness Supervisor at 303.805.3278.

Personal Information

Teammates

Name: _____ DOB/Age: _____
Gender: M F Height: _____ Weight: _____

Current Information

Address: _____ Daytime Phone: _____
City: _____ State: _____ Zip: _____ Evening Phone: _____
Email: _____

Emergency Contact Information

Name: _____ Relation: _____
Home Phone: _____ Work Phone: _____

How did you learn about Parker Parks and Recreation's Personal Training and Private Instruction Services?

____ Recreation Brochure ____ Mobile App ____ Friend
____ Recreation Website ____ Other (please explain) _____

Training Preferences and Availability (Bios are available by visiting www.ParkerRec.com/PersonalTrainer.)

My preferred Trainer is: _____

I would prefer to train at the following location:

Parker Recreation Center (17301 E. Lincoln Ave., Parker): _____

Parker Fieldhouse (18700 E. Plaza Dr., Parker): _____

Please indicate the days and times you are available and prefer to train. (Please be specific, the more flexible your time the easier to match a Trainer.)

Monday: _____ Thursday: _____ Saturday: _____
Tuesday: _____ Friday: _____ Sunday: _____
Wednesday: _____

Please indicate your current levels of satisfaction:

	Very Dissatisfied		Dissatisfied			Satisfied			Very Satisfied		
Weight	1	2	3	4	5	6	7	8	9	10	
Body Composition	1	2	3	4	5	6	7	8	9	10	
Physical Activity Level	1	2	3	4	5	6	7	8	9	10	
Use of Tobacco Products	N/A	1	2	3	4	5	6	7	8	9	10
Blood Pressure & Cholesterol	1	2	3	4	5	6	7	8	9	10	
Muscular Strength & Endurance	1	2	3	4	5	6	7	8	9	10	
Cardiovascular Endurance	1	2	3	4	5	6	7	8	9	10	
Stress Levels	1	2	3	4	5	6	7	8	9	10	
Nutrition & Eating Habits	1	2	3	4	5	6	7	8	9	10	
General Health & Lifestyle	1	2	3	4	5	6	7	8	9	10	

What goals would you like to achieve from participating in services? _____

Medications/Allergies

Please list any medical concerns/conditions that might limit your ability to participate in services (pregnancy, disability, chronic conditions, etc.):

Please list any known allergies (environmental, medications, food, etc.):

Please list current medications including over-the-counter medications, prescriptions, etc. that may affect your body's response to exercise.

Medication	Dosage	For What?

Exercise History and Attitude

1. Have you been involved in a routine of regular aerobic exercise (moderate, continuous activity for at least 15-20 minutes duration, at least 3 days per week)? _____yes _____no

If yes, for how long and what activities? _____

If no, when was the last time you can recall being active for at least 20 minutes? What activity were you doing?

2. Are you currently involved in a weight training and conditioning program? _____yes _____no

Min/Day _____ Days/Week _____

If yes, please explain/summarize your current program (exercises, free weights, goals, etc.)

3. Check the activities you would consider doing and circle the activities you consider "fun."

____ Walking ____ Group Fitness Classes ____ Strength Training ____ Athletic Drills
____ Swimming ____ Jogging ____ Cycling ____ Cardio Machines ____ Rowing

Other activities you are interested in? _____

4. How much time are you planning to devote to a fitness regimen?

On your own time: _____days/week _____minutes/day

Meeting with a Trainer: _____days/week



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C O L O R A D O

Parks and Recreation

Waiver of Liability and Release

I, the undersigned participant/parent or guardian of the participant, recognize and acknowledge that activities with the Town of Parker Parks and Recreation Department involve risk of serious injury, including permanent disability or death, and severe social and economic losses which might result from participant action, inaction, negligence of others, rules of play, or the condition of the premises or any equipment used thereon. Further, I understand that there may be other risks not known or reasonably foreseeable at this time and that such risks shall be assumed by the undersigned.

In my absence, I authorize the employees of the Town of Parker and the instructor or coach of my (my child's) team/activity to call for emergency rescue services for _____ should they be necessary in the case of injury or suspected injury, or during the times that the above named individual is participating in an activity sponsored by the Parker Parks and Recreation Department. I authorize the attending physician at the hospital to administer necessary emergency medical care to the above individual upon arrival at the hospital. I will accept responsibility for the payment of any and all treatment provided therein including emergency rescue services.

Before meeting a Parker Parks and Recreation Personal Trainer, or engaging in a training program, I certify that I have answered all health and fitness questions honestly and to the best of my ability. I understand the importance of providing complete and accurate responses. I understand that I may have to provide a medical clearance from my doctor prior to participating in any Parker Parks and Recreation personal training or private instruction services.

I certify that the above named is capable of participating safely in Town of Parker Parks and Recreation Department programs. I understand that the Town of Parker does not provide accident, health, or life insurance coverage for the above named participant during program participation.

I further understand that I am legally responsible for actions of the above named individual including, but not limited to, any damage to private or public property. I am legally responsible for my own and/or my child's welfare and actions including personal needs and medical expenses.

I agree to indemnify and hold the Town of Parker, its officers, agents, consultants, and representatives harmless from any loss, damage, or injury which may result from my or my child's participation in activities sponsored by the Town of Parker Parks and Recreation Department. This release of liability and indemnity applies equally to losses, damages, or injuries caused or alleged to be caused in whole or in part by the negligence of the Town. I further agree to release, waive and discharge, and covenant not to sue the Town for any claims, demands, or actions whatsoever arising out of any damage, loss, or injury incurred on or to me or my child as a result of my participation or my child's in activities sponsored by the Town. This release of liability and indemnity applies to me, the undersigned, or my child, as well as any personal representatives, assigns, heirs and next of kin.

Finally, I give my consent to use any photographs or videotape taken of me (my child) while participating in any Town of Parker Parks and Recreation Department program in future promotional or marketing materials.

I have read and fully understand the effect of the relinquishment of the rights that I hereby waive.

Terms and Conditions

I agree to adhere to all Parker Parks and Recreation's personal training and private instruction policies and procedures:

Please initial.

____ All members agree to abide by the Recreation Department facility rules and regulation and Code of Conduct while in the facility. These rules and regulations may change from time to time. Failure to abide by the centers rules and regulations may result in termination of membership.

____ Patrons must use the identification card to check in to the front desk, get a receipt for each session and give the receipt to the trainer.

____ Patrons wishing to use the facility before or after a scheduled session must pay the daily admission or use their membership card.

____ Full payment is due prior to services being received and payment cannot be accepted by the trainer.

____ If I need to cancel my session I must call my trainer at least 24 hour prior to my scheduled session. If I do not call 24 hours prior, that session will be forfeited, including first time sessions.

____ If I am late, the session will only last until the end of the hour for which that session was scheduled. If I am more than 15 minutes late the scheduled session will be forfeited.

____ If my health status changes after completing the registration packet, I will inform my trainer immediately. I understand that I may need to obtain a physician's clearance prior to continuing training sessions.

Signature (required) _____ Date _____

Guardian Signature: _____

PAR-Q+






The Physical Activity Readiness Questionnaire for Everyone

Regular physical activity is fun and healthy, and more people should become more physically active every day of the week. Being more physically active 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.

SECTION 1 - GENERAL HEALTH


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?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
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).	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you currently taking prescribed medications for a chronic medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
6) Do you have a bone or joint problem that could be made worse by becoming more physically active? Please answer NO if you had a joint problem in the past, but it does not limit your current ability to be physically active. For example, knee, ankle, shoulder or other.	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your doctor ever said that you should only do medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>

 If you answered NO to all of the questions above, you are cleared for physical activity. Go to Section 3 to sign the form. You do not need to complete Section 2.

-  Start becoming much more physically active – start slowly and build up gradually.
-  Follow Canada's Physical Activity Guidelines for your age (www.csep.ca/guidelines).
-  You may take part in a health and fitness appraisal.
-  If you have any further questions, contact a qualified exercise professional such as a CSEP Certified Exercise Physiologist® (CSEP-CEP) or a CSEP Certified Personal Trainer® (CSEP-CPT).
-  If you are over the age of 45 yr and NOT accustomed to regular vigorous physical activity, please consult a qualified exercise professional (CSEP-CEP) before engaging in maximal effort exercise.

 If you answered YES to one or more of the questions above, please GO TO SECTION 2.

 Delay becoming more active if:

-  You are not feeling well because of a temporary illness such as a cold or fever - 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+ before becoming more physically active OR
-  Your health changes - please answer the questions on Section 2 of this document and/or talk to your doctor or qualified exercise professional (CSEP-CEP or CSEP-CPT) before continuing with any physical activity programme.

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SECTION 2 - CHRONIC MEDICAL CONDITIONS

1. **Do you have Arthritis, Osteoporosis, or Back Problems?**
YES If yes, answer questions 1a-1c NO 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 have Cancer of any kind?**
YES If yes, answer questions 2a-2b NO 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 neck? YES NO
- 2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)? YES NO
-
3. **Do you have Heart Disease or Cardiovascular Disease? This includes Coronary Artery Disease, High Blood Pressure, Heart Failure, Diagnosed Abnormality of Heart Rhythm**
YES If yes, answer questions 3a-3e NO 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 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
- 3e. 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 any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes**
YES If yes, answer questions 4a-4c NO If no, go to question 5
- 4a. Is your blood sugar often above 13.0 mmol/L? (Answer YES if you are not sure) YES NO
- 4b. Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, and the sensation in your toes and feet? YES NO
- 4c. Do you have other metabolic conditions (such as thyroid disorders, pregnancy-related diabetes, chronic kidney disease, liver problems)? YES NO
-
5. **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**
YES If yes, answer questions 5a-5b NO 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 also have back problems affecting nerves or muscles? YES NO

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6. **Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure**

YES If yes, answer questions 6a-6d NO 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. 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

6c. 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

6d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? YES NO

7. **Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia**

YES If yes, answer questions 7a-7c NO 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. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? YES NO

7c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)? YES NO

8. **Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event**

YES If yes, answer questions 8a-c NO 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 have any impairment in walking or mobility? YES NO

8c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? YES NO

9. **Do you have any other medical condition not listed above or do you live with two chronic conditions?**

YES If yes, answer questions 9a-c NO If no, read the advice on page 4

9a. 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





9b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)? YES NO

9c. Do you currently live with two chronic conditions? YES NO

Please proceed to Page 4 for recommendations for your current medical condition and sign this document.

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

-  It is advised that you consult a qualified exercise professional (e.g., a CSEP-CEP or CSEP-CPT) 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 - 20-60 min 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 physical activity, please consult a qualified exercise professional (CSEP-CEP) before engaging in maximal effort 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. It is recommended strongly that you complete the specially designed online screening and exercise recommendations program (i.e., the ePARmed-X+; www.eparmedx.com) and/or visit a qualified exercise professional (CSEP-CEP) for further information.

 **Delay becoming more active if:**

-  You are not feeling well because of a temporary illness such as a cold or fever - 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+ before becoming more physically active OR
-  Your health changes - please talk to your doctor or qualified exercise professional (CSEP-CEP) before continuing with any physical activity programme.

SECTION 3 - DECLARATION

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The PAR-Q+ Collaboration, the Canadian Society for Exercise Physiology, and their agents assume no liability for persons who undertake physical activity. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.
- 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.

Please read and sign the declaration below:

(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 centre, health care 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 they maintain the privacy of the information and do not misuse or wrongfully disclose such information.

NAME _____

DATE _____

SIGNATURE _____

WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact
www.eparmedx.com or
Canadian Society for Exercise Physiology
www.csep.ca

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Deane E. R. Warburton with Dr. Florence Gladhill, Dr. Veronica Jansik, 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 BC Ministry of Health Services.

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Key References:

1. Jansik VE, Warburton DE, Gladhill F, McKenzie DC, Shephard R, Shew L, and Gladhill R. Reliability of clearance for physical activity participation: background and methods. *Physical Activity Monitoring Questionnaire (PAR-Q+) and Related Physical Activity Monitoring Questionnaire (PARmed-X+)*. Health Canada, Ottawa, Canada: 2010; 1-23, 2010.