Personal Training Registration Form

Welcome to the University of Idaho Student Recreation Center’s Personal Training Program. As you fill out the following paperwork, please be accurate and honest so we can best assess the information you provide. A trainer will then contact you shortly to set up a time to meet. Hold onto this form until your consultation!

Nutrition is a vital part to a successful wellness program. If you would like, you can record a three-day diet diary, and the trainer will give suggestions that would further help you achieve your training goals (Personal Trainers are not able to write you a personalized diet plan).

Please contact Ben to set up a consultation or if you have any questions about personal training.

Ben Sturz  
Director of Recreation and Fitness Services  
208 885-2204  
bsturz@uidaho.edu

PLEASE DO NOT LEAVE THIS DOCUMENT AT THE SRC FRONT DESK. GIVE THIS FORM TO THE STAFF MEMBER CONDUCTING YOUR CONSULTATION.

Cancellation, Late, & Refund Policy

Cancellation Policy
It is the responsibility of you, the client, to provide 12 hours notice prior to a scheduled training and/or fitness assessment session if a cancellation is needed. If a training session is cancelled appropriately, it is the trainer’s and client’s responsibility to reschedule. If appropriate notice of cancellation is not provided the client will be charged in full for the missed training session.

Late Policy
Trainers must wait 15 minutes for their client. If the client fails to meet the trainer before 15 minutes of their session has passed, the session is considered a no show and will be deducted from their purchased sessions.

Refund Policy
All sales are final and requests for refunds will only be accepted based upon medical necessity, or in case of significant emergencies. Documentation of medical condition or other emergencies may be required to request a refund. All refund requests will be reviewed and completed on a case-by-case basis.

Please sign below indicating you understand and agree to abide by the University of Idaho Personal Training Cancellation, Late, & Refund Policies.

Printed Name

Signature

Date
Personal Training Client Information Form

Last Name: ___________________________ First Name: ___________________________ MI: _____

Date of Birth: ____________ Primary Telephone: (_____) _______ - ________

Email Address: _________________________ Vandal Card # (If Applicable): ____________

Requested Trainer: Name: ___________________________ or Male / Female / Any (circle one)

What Are Your Training Goals?

Short-Term (3 Months):

Long-Term (12 Months or more):

Preferred Training Schedule – Please check the days you are available and provide your open times on those days

<table>
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<th>Monday</th>
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<tr>
<td>Availability</td>
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Packages & Services – For ALL new clients a Fitness Assessment is required and will be the first session of any package purchased. All sessions & packages expire 1 year from date of purchase.

Consultation ($42.50) (55 minutes)
  - Discusses your current health and fitness habits and allows you to work with a trainer to refine and achieve your goals. (This service does not include personalized exercise programs).

Multiple Sessions (All sessions are 55 minutes)
  - 1 Session: ($42.50)
    o For current clients who have been actively working with a UI trainer.
  - 4 Sessions: ($160)
    o Best option to go over basic body mechanics, learning new equipment and exercises, and/or refining skills to progress you to the next level. This option is ideal for someone with previous gym experience that just needs occasional check-in but is also a good option for beginners.
  - 10 Sessions: ($375)
    o Best option for beginners that want to build better habits but are unsure of where to begin. During these sessions you will be given a strong foundation of correct exercise form, an introduction to fitness equipment, development of exercise terminology, and confidence to conquer the gym on your own.
  - 20 Sessions: ($700)
    o Best option for anybody that wants to train long-term with a trainer to ensure their exercise regimen remains progressive, safe, individualized, and for those looking for long-term help with consistency.

Partner Personal Training – Clients must have similar availability, goals, and fitness levels. Please contact Ben for rates.
Emergency Contact Information

Name: ___________________________ Relation: ___________________________

Home Telephone: (_____) _______ Work Telephone: (_____) _______

Acknowledgement of Risk and Waiver of Liability

Both participants and parent(s)/guardians must read this Acknowledgement of Risk and Waiver of Liability carefully and in its entirety. It is a binding legal document. Please read both sides of this page. Sign and return this form to Activity Coordinators. If you are under the age of 18, this form must be signed by you as the participant and by your parent or legal guardian.

I, the undersigned participant or parent/guardian, am aware that participation in Student Recreation Center Programs, Events and Facilities Use ("Activity") may include activities that are risky and dangerous. Both participant and his/her parent(s)/guardian(s) ("I") acknowledge and accept the risks and give permission for my participation in the Activity. I acknowledge that participation in this Activity has the following non-exhaustive list of particular activities that bear risk and danger and from which bodily injury or illness to myself, or my child, up to and including death, may occur: physical and sporting activities related to athletic fitness, training, practice and competition including, but not limited to aerobic movements, balancing, bending, falling, jumping, lifting heavy objects, pulling, movements, running, stretching, throwing, twisting, and competition in and/or practice of activities that involve strenuous exertion that could place stress on cardiovascular and/or musculo-skeletal systems and result in broken bones, cuts, punctures, strain, sprains, joint and tendon injuries, heart malfunctions, eye injuries, head injuries and serious neck or spinal injuries that may result in complete or partial paralysis or brain damage; use or operation, by me or others, of all equipment in the condition in which they are found; activities supplemental to the Activity, such as walking or hiking to and from sites of interest; use of facilities, roads, sidewalks, parking lots, and trails that may or may not be properly maintained; contact with animals, plants, insects, biological and environmental hazards; exposure to contaminated food and untreated water; risk related to the rendering or receipt of emergency first aid, or other emergency treatment, and transport in medical emergencies; accident or illness in locations without access to appropriate medical facilities or supplies; exposure to infectious disease and/or illnesses; and other unknown and unanticipated activities and risks.

In consideration of the University of Idaho ("UI") permitting me/my dependent to participate in the Activity, I and my dependent hereby voluntarily accept all risks associated with participation. To the extent permitted by law, I agree to indemnify, defend, save, hold harmless, discharge and release the State of Idaho, the Regents of the University of Idaho, their agents and employees from any and all liability, claims, causes of action or demands of any kind and nature whatsoever that may arise out of or in connection with my participation in any activities related to the above named Activity.

It is my express intent that this Acknowledgement of Risk and Waiver of Liability shall serve as a release, discharge and acceptance of risk for my heirs, estate, executors, administrator, assigns and all members of my family. The venue of any dispute that may arise out of or from my dependents' participation in the Activity, if the University is a party to the dispute, shall be in Latah County, Idaho.

I understand I am responsible for all medical expense and/or property losses.

I am aware that if I provide a vehicle not owned and operated by the University for transportation to, at, or from any Activity site, or if I am a passenger in such a vehicle, the University is not responsible for any damage or injury caused by or arising from my use of such transportation. Furthermore, I acknowledge that I am solely responsible for any action that I take that is outside the scope of the scheduled Activity, regardless if occurring before, during or after the period of the Activity. I acknowledge that the University makes no representation with respect to the safety of any personally owned vehicle in which I may travel, or with respect to the qualifications of the driver of any personally owned vehicle. I understand that if I choose to travel in a personally owned vehicle, it is my responsibility to determine the safety of the vehicle and qualifications of the driver.

I hereby certify that, with or without accommodation, I and/or my dependent is in good health and I know of no medical reason why I/he/she is not able to participate in this Activity. I hereby consent to first aid, emergency medical care and if necessary, admission to an accredited hospital when necessary for executing such care, for treatment for injuries or illnesses that I/he/she may sustain while participating in any activity associated with the above named Activity.

If my dependent has a disability, food or drug allergy, dietary requirements, or any condition requiring accommodation, I will contact Center for Disability Access and Resources (208) 885-6307 at least three weeks (21 days) prior to the start of the Activity.

Whether or not I am a student, I will abide by the University of Idaho Student Code of Conduct, Articles II through IX at https://www.uidaho.edu/governance/policy/policies/is/2/100; the behavioral expectations of the Activity; and all applicable city, state and federal laws. My failure to do so may be considered grounds for denying my/my dependent’s participation in the Activity.

Note: If participant is under 18 years of age, a parent/legal guardian must also sign and accept responsibility for the participant’s actions and terms of the above agreement.

PARENT(S) / GUARDIAN(S) SIGNATURE

Parent/Guardian Name [PLEASE PRINT]:
Parent/Guardian Signature:
Date:

PARTICIPANT’S SIGNATURE

Participant’s Name [PLEASE PRINT]:
Participant’s Signature:
Date:
# 2021 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.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>1) Has your doctor ever said that you have a heart condition ☐ OR high blood pressure ☐?</td>
<td></td>
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<tr>
<td>2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?</td>
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<tr>
<td>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).</td>
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<tr>
<td>4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:</td>
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<tr>
<td>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:</td>
<td></td>
<td></td>
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<tr>
<td>7) Has your doctor ever said that you should only do medically supervised physical activity?</td>
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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://www.who.int/publications/i/item/9789240015128).
- 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.

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01-11-2020
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 spondylosis/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 chemotherapy 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 shaking, 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 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)

6b. Do you have Down Syndrome AND back problems affecting nerves or muscles?

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)

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?

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?

7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?

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)

8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?

8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?

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)

9b. Do you have any impairment in walking or mobility?

9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?

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?

10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?

10c. Do you currently live with two or more medical conditions?

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

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**GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.**
2021 PAR-Q+

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+

Key References

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 Janmik, 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.