OU FIT + REC

New Client
Assessment/Training Request Form

To protect your privacy, return completed form to the front desk of the Sarkeys Fitness Center or with OU email address to lraymond@ou.edu. If OU email address is not available, include [ouencrypt] in subject line of email.

_____ _____ _____
Name Date Age

_____ _____ _____
Preferred Phone OU Email Address (if applicable) OU or SFC ID# (If Applicable)

Please select which best applies to you:

1. Student ☐ Faculty /Staff ☐ Alumni ☐ Retiree ☐ Additional Member ☐
2. Gender Identity: _____ Pronouns: _____

Service Type:

❒ Fitness Assessment Only ❒ Personal Training

❒ Small Group Training: Number of people in group (5 maximum): _____

For Small Group Training, the Fitness Assessment will still be performed individually for each group member. Fee for assessment is $40 + tax. Training sessions will be at rate based on number of group members.

List names of additional group members: _____

_____

Briefly describe goals for Assessment/Personal Training/Small Group Training below:

Appointment Preferences - select all that apply:

Frequency:	❒ 3-4 times to help me get started*	❒ 1 x week	❒ 2 x week	❒ 3 x week	❒ Other:
Day(s) of Week:	❒ Monday ❒ Tuesday ❒ Wednesday ❒ Thursday ❒ Friday ❒ Saturday ❒ Sunday				
Time of Day:	Preference 1:		Preference 2:		Preference 3:
Other Scheduling Preferences/Notes:					

**This includes a fitness assessment and 2-3 sessions to ensure movements can be performed safely and effectively.*

Would you prefer a female or male Personal Trainer (please select)?

❒ Female ❒ Male ❒ No Preference

Are you interested in training with a particular Personal Trainer? Yes No

If "yes," whom? _____

Once your request has been reviewed, you will be contacted by a Fitness and Recreation representative. After assigned, your trainer will contact you within 48 hours to make your Initial Assessment training appointment.

For Office Use Only

Received by: _____ Date: _____ Trainer: _____Intro Email: _____In Fusion: _____

Notes: _____

_____

2023 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://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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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+
Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

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.

01-11-2022

University of Oklahoma Norman Campus
WAIVER and RELEASE of LIABILITY

This is a legal and binding agreement which, when signed, will permanently limit your ability to recover from the University for injuries or losses you may cause or sustain as a result of participation in on or off-campus activities.

The University of Oklahoma is a state educational institution. References to the University of Oklahoma include its Board of Regents, officers, agents, faculty, employees, volunteers, students, UOSA and administrative organizations.

I [*print your name*] _____ freely choose to participate in the usage of Fitness and Recreation facilities as a member or guest, which may include the following activities:

Intramural Sports	Rock Wall/Climbing	Personal Training	Wellness Coaching
Individual/Team Fitness	FIT Classes/F45	Aquatics Activities	

I understand that the University of Oklahoma is not an agent of and has no responsibility for any third party that may provide services including food, lodging, travel, or equipment. The University of Oklahoma has not reviewed the qualifications of the Activity organizer or sponsor, and does not endorse or sponsor the program or its safety or quality.

For off-campus activities, I agree to inform myself about the potential dangers of the area I am traveling to and precautions I should take, including reviewing the State Department Consular Travel Information at http://www.travel.state.gov and the Centers for Disease Control Travelers Information at http://www.cdc.gov/travel/ for health and immunization information, and any other information that the Activity organizer, sponsor or the University may provide.

For a "Wilderness" trip, I understand that it may take 48 hours or more to arrive at a medical facility, transportation to which may be by boat or on foot. I accept the increased risk that such isolation may pose in the event of injury.

I understand that it is my responsibility to acquire and use activity-appropriate and/or required equipment and protection. I agree to reduce the risk of injury to myself and others by following applicable rules and procedures, by limiting my participation to reflect my personal fitness level and by notifying the Activity coordinator immediately if I do not believe I can safely continue in the Activity. I agree that if I fail to act in accordance with this agreement I may not be permitted to continue in the Activity.

Despite precautions, accidents and injuries can and do occur. I understand that the Activity and transportation may be dangerous and that I may be injured and/or lose or damage personal property as a result of participation in the Activity. Therefore, **I FULLY AND COMPLETELY ASSUME ALL RISKS RELATED TO THE ACTIVITIES** including death, injury, illness or loss from accidents, theft of or damage to personal belongings. I further ASSUME ALL LIABILITY for any loss, related to the activity and caused by my actions, to another party including death, injury, illness or loss from accidents, or damage to property.

Medical Treatment Authorization

I authorize the University of Oklahoma to act on my behalf in any medical emergency.

_____

Signature Date

(Signature of Parent or Legal Guardian is required if participant is under 18.)

Release from Liability, Indemnification Agreement and Covenant Not to Sue

To the fullest extent permitted by law, on behalf of myself, my spouse, heirs, representatives, executors, administrators and assigns, I agree to forever RELEASE, INDEMNIFY, HOLD HARMLESS and COVENANT NOT TO SUE the University of Oklahoma from any cause of action, claim, or demand, including one related to bodily injury, property damage, death or accident arising out of or related to my participation in the Activity.

I hereby release F45 Training its related body corporates and affiliates, their officers, agents and employees (the "**RELEASED PARTIES**") from any claims, demands, and causes of action as a result of my voluntary participation in all F45 programs to the fullest extent permitted by law.

I assure the University of Oklahoma that I have adequate health insurance to provide for any medical needs or costs that may result from my participation in the Activity.

My signature below indicates that I have read, understood, and freely signed this agreement, which shall take effect as a sealed instrument. I further certify that my date of birth is _____ (month/day/year), and that my present age is _____, and that I am otherwise legally competent to sign this agreement.

This agreement shall be construed and enforced in accordance with the laws of the State of Oklahoma, and I consent to the jurisdiction of this state. I expressly agree that this waiver and release is intended to be as broad and inclusive as permitted and that if any portion is held invalid, the remainder shall continue in full legal force and effect.

Fitness and Recreation Locker Waiver

By voluntarily placing my personal items in the University of Oklahoma lockers at the Sarkeys Fitness Center and/or Murray Case Sells Swim Complex, I understand, recognize and agree that the University shall not be responsible for any of my items which are lost, stolen or damaged. Further, I understand all items must be removed from my locker immediately upon the end of my contract or my locker will be cleared of my belongings. My belongings will then enter the University property disposal system. I agree not to store any illegal or prohibited items. I understand that this facility is subject to search and this serves as my consent to such search. I understand that the searched items may be confiscated by the University and/or law enforcement officials.

Get Active Questionnaire

It is recommended that prior to beginning an exercise program, annually, or as your health status changes, to take a health and fitness self-assessment to determine if a doctor should be consulted to discuss your risk factors. A Get Active Questionnaire is available at the front desks of the Sarkeys Fitness Center and Murray Case Sells Swim Complex to assist with this process.

My signature below indicates I am at least 18 years of age and I have read, understand, and freely signed this agreement.

*** * * * * IMPORTANT - READ ENTIRE AGREEMENT BEFORE SIGNING * * * * ***

Printed Name _____

Signature _____

Date _____

Address_____

_____

Phone _____

If Participant is under the age of 18

Parent's Printed Name_____

Parent's Signature _____

Parent's Address _____

_____

Parent's Phone(s)_____

Guest Waiver Sponsor Information

Name- Print Clearly _____

ID#_____