Client Registration Packet may be completed and submitted to appropriate Fitness Coordinator prior to first session or submitted to the assigned trainer at first session.

New clients must purchase first session prior to scheduling.

Personal Training and
Private Pilates, Yoga,
and Tai Chi Instruction

Client Registration

-Confidential-
<table>
<thead>
<tr>
<th>Personal Training</th>
<th>Individual Personal Training (Ages 10 and up)*</th>
<th>Group Personal Training (2-4 people)</th>
<th>30 Minute Individual Personal Training**</th>
</tr>
</thead>
<tbody>
<tr>
<td>R=Resident NR=Non-resident</td>
<td>R</td>
<td>NR</td>
<td>R</td>
</tr>
<tr>
<td>1 Session</td>
<td>$50</td>
<td>$60</td>
<td>$64</td>
</tr>
<tr>
<td>3 Sessions</td>
<td>$141</td>
<td>$171</td>
<td>$183</td>
</tr>
<tr>
<td>5 Sessions</td>
<td>$225</td>
<td>$275</td>
<td>$295</td>
</tr>
<tr>
<td>10 Sessions</td>
<td>$430</td>
<td>$530</td>
<td>$570</td>
</tr>
</tbody>
</table>

*Youth (10-17) receive a 10% discount on packages of 3, 5, and 10 hour sessions for individual personal training. No youth discount for single sessions, group training or 30 minute personal training.

**NEW 30 MINUTE CLIENTS are required to complete a single 60 minute session at $50R/$60NR for their initial session, then will purchase a 30 minute package. 30 minute personal training is not available for groups.

### Private Pilates Reformer

<table>
<thead>
<tr>
<th>Private Pilates Reformer</th>
<th>Individual Pilates Reformer Training</th>
<th>Group Pilates Reformer Training (2-4 people)</th>
</tr>
</thead>
<tbody>
<tr>
<td>R=Resident NR=Non-resident</td>
<td>R</td>
<td>NR</td>
</tr>
<tr>
<td>1 Session</td>
<td>$55</td>
<td>$66</td>
</tr>
<tr>
<td>3 Sessions</td>
<td>$156</td>
<td>$189</td>
</tr>
<tr>
<td>5 Sessions</td>
<td>$250</td>
<td>$305</td>
</tr>
<tr>
<td>10 Sessions</td>
<td>$480</td>
<td>$590</td>
</tr>
</tbody>
</table>

### Personal Training and Private Instruction Policies (Please Read Carefully)

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 you complete it 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 Front Desk, Registration Desk or online through ssprd.org.

4. **Call the recreation center of your scheduled session 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 hours in advance or session will be forfeited. Call your Trainer or the Recreation Center front desk to leave a message for your Trainer.**

6. Be ready to work hard during each session; wear athletic type shoes and clothing; bring a towel and water bottle.

### Client Confidentiality

Information will not be released without the individual’s permission, except in emergency situations. Client registration packet will remain in South Suburban Parks and Recreation files for seven years following the cessation of your participation in the program.

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 appropriate coordinator:

Buck Fitness Coordinator at (303) 730-4610, Goodson and Sheridan Personal Trainer Coordinator at (303) 483-7089 or the Lone Tree Fitness Coordinator at (303) 708-3514.
Personal Information

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: ___________________________

Training Preferences and Availability (Bios are available by visiting www.ssprd.org and selecting the appropriate facility)

Type of training desired (please circle one):

Personal Training  Private Reformer  Private Tai Chi  Private Yoga

My preferred trainer is: ___________________________________________

I would prefer to train at the following location(s):


Goodson Recreation Center (6315 S. University Blvd, Centennial): ______

Lone Tree Recreation Center (10249 Ridgegate Circle, Lone Tree): ______

Sheridan Recreation Center (3325 W. Oxford Ave, Denver): ______

Please circle the day(s) and list the time(s) you are available and prefer to train. (The more flexible your availability, the easier it will be to match you to a trainer.)

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
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</table>

Preferred Time(s): ______  ______  ______  ______  ______  ______  ______  ______

How long are you planning on working with a trainer? (A few sessions, a few months, ongoing)?
Exercise History

Are you currently involved in a routine of regular aerobic exercise or a weight training program? ___ yes ___ no

• If yes, for how long and how often? What activities?

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

Check the activities you are currently involved in and circle activities you would consider doing in the future.

___ Walking/Jogging    ___ Strength Training    ___ Group Fitness Classes    ___ Athletic Drills
___ Swimming          ___ Cycling             ___ Cardio Machines

What other activities you are interested in?

Goals

What goals would you like to achieve from participating in this service?

Known Medical Concerns/Conditions

Please list any known injuries, trouble spots, recent surgeries, or other medical concerns and conditions that might limit your ability to participate in services (pregnancy, disability, replaced joints, chronic conditions, etc.).

Medications/Allergies

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.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>For What?</th>
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</thead>
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<tr>
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</table>
Informed Consent

I, ____________________________, understand participation in recreation activities and services may have an element of hazard or inherent danger, and users take full responsibility for their actions and physical condition. Users agree to indemnify and hold harmless the South Suburban Parks and Recreation District and its employees and agents for any liability, loss, cost or expense (including attorney’s fees, medical, ambulance cost) that users may incur while participating in any Parks and Recreation activities.

Before meeting with a South Suburban Parks and Recreation Trainer, taking part in fitness testing, 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 recognize that my failure to do so could lead to possible unnecessary injury to myself during fitness testing and/or exercise programs. I understand that I may have to provide a medical clearance from my doctor prior to participating in any South Suburban Parks and Recreation personal training or private instruction services.

Signature: ____________________________ Date: _________
Guardian Signature: ____________________________ Date: _________
(Required if participant is under the age of 18)

Terms and Conditions

I agree to adhere to all South Suburban Parks and Recreation District’s personal training and private instruction policies and procedures.

(Please initial)

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

_____ If I need to cancel an appointment, I must call the appropriate Recreation Center or my trainer at least 24 hours prior to my scheduled session/appointment. If I do not call 24 hours prior, that session will be forfeited, including first time sessions.

_____ If I am late (<15 min), 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.

_____ I will check in at the facility front desk before every session, and ensure they remove a training session from my account for that day.

_____ Personal training packages expire 3 years after the date of purchase. I understand that personal training, private reformer, and massage packages are not eligible for refunds, credits, or transfers.

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

Signature: ____________________________ Date: _________
Guardian Signature: ____________________________ Date: _________
(Required if participant is under the age of 18)
Please read the 7 questions below carefully and answer each one honestly: check YES or 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.

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.
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 spine 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. How 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**
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

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?

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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

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

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

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?

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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

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.**
2023 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 ____________________________________________________________
SIGNATURE ________________________________________________________
DATE _____________________________________________________________
WITNESS __________________________________________________________

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER ________________________

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

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
Clinicin’s Release for Activity

It is my understanding that _____________________________(name), may be participating at a South Suburban Recreation Center in exercise and/or fitness activities.

As the individual’s physician/medical provider, I am aware of medical condition(s) that would limit him/her. Any restrictions and specific guidelines (if needed), are indicated below.

Cardiovascular

- Treadmill
- Upright Stationary Cycle
- Recumbent Stationary Cycle
- Swimming
- Stair Climber
- Rowing
- Elliptical Trainer

Strengthening and Flexibility Activities

- Legs
- Chest
- Upper Back
- Abdominal
- Lower Back
- Shoulder
- Arms

Pilates/Yoga

Amenity

- Jacuzzi/Whirlpool
- Steam

Specific comments regarding limitations or contraindications for activity:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Physician/Medical Provider Name                                 Phone Number
____________________________________________________________________________________
____________________________________________________________________________________

Physician/Medical Provider Signature                                             Date
____________________________________________________________________________________

Please return to: South Suburban Parks and Recreation
Goodson Recreation Center
Personal Training Coordinator
6315 S. University Blvd.
Centennial, CO  80121-2914
Fax:  303-730-2654