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.

SOUTH SUBURBAN
PARKS & RECREATION

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

Client Registration

-Confidential-

South Suburban Personal Training and Private Instruction Services Summary and Costs

Adult Personal Training, Yoga, Tai Chi & Mat Pilates	One on One Hourly		Youth Personal Training (Ages 10-17)		Group Personal Training (2-4 people)	
R=Resident NR=Non-resident	R	NR	R	NR	R	NR
1 Session	$47	$57	$43	$52	$61	$72
3 Sessions	$132	$165	$120	$141	$174	$207
5 Sessions	$210	$265	$190	$225	$280	$335
10 Sessions	$400	$510	$360	$430	$540	$650

30 Minute One on One Personal Training			Pilates Reformer	Private Pilates Reformer		Pilates Reformer Group (2-4 people)	
Starter Pack	R	NR		R	NR	R	NR
1 hour session and 3 half-hour sessions	$128	$154	1 Session	$52	$63	$70	$82
5 Sessions	$140	$165	3 Sessions	$147	$180	$201	$237
10 Sessions	$250	$300	5 Sessions	$235	$290	$325	$385
*Starter pack required for all new 30 minute clients.			10 Sessions	$450	$560	$630	$750

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 sevan 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.)

My preferred trainer is: _____

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

Douglas H. Buck Community Center (2004 W. Powers Ave, Littleton): _____

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 indicate the days and times you are available and prefer to train. (The more flexible your availability, the easier it will be to match you to a trainer.)

Monday: _____ Tuesday: _____ Wednesday: _____Thursday: _____

Friday: _____ Saturday: _____ Sunday: _____

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

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.

Medication	Dosage	For What?

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.

_____ Personal training sessions do not expire. Requests for cancellations/cash refunds are not permitted 12 months after the original purchase date. If there is something that would prohibit me from participating in personal training, I may submit a request in writing to the fitness coordinator with sufficient proof of why I can't continue with training sessions. A doctor's note or change of address form may be requested. SSPRD reserves the right to deny cancellation requests made 12 months after purchase.

_____ 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)

2019 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 International Physical Activity Guidelines for your age (www.who.int/dietphysicalactivity/en/).
- 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.

2019 PAR-Q+

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 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.

11-01-2018

Please Do Not Fill Out Unless Requested By Fitness Coordinator

Clinician'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

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

Strengthening and Flexibility Activities

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

Pilates/Yoga

Amenity

- o Jacuzzi/Whirlpool
- o 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