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-

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.
- 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 Info	ormation		
Name:		Relation:	·
Home Phone:		Work Ph	one:
Training Preferences ar	nd Availability (Bios are ava	ilable by visiting www.sspi	d.org and selecting the appropriate facility.)
My preferred trainer is:			
I would prefer to train a	nt the following location(s	;):	
Douglas H. Buck Cor	mmunity Center (2004 W	. Powers Ave, Littleton	:
Goodson Recreation	Center (6315 S. Universi	ity Blvd, Centennial):	
Lone Tree Recreation	n Center (10249 Ridgega	ite Circle, Lone Tree):	
Sheridan Recreation	Center (3325 W. Oxford	Ave, Denver):	
Please indicate the day the easier it will be to n		able and prefer to train	. (The more flexible your availability,
Monday:	_ Tuesday:	Wednesday:	Thursday:
Friday:	Saturday:	Sunday:	
How much time are you	ı 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 plant	ning on working with a tro	ainer? (A few sessions,	a few months, ongoing)?

Exercise History

Are you currently involved in a routi	ne of regular aerobic e	exercise or a weight trainii	ng program? yes no
 If yes, for how long and how of 	ften? What activities?		
 If no, when was the last time y doing? 	ou can recall being ac	tive for at least 20 minute	s? What activity were you
	y involved in and circle	e activities you would cons	sider doing in the future.
Walking/Jogging	Strength Training	Group Fitness Classes	Athletic Drills
Swimming	Cycling	Cardio Machines	
What other activities you are inte	rested in?		
	<u>Go</u>	<u>als</u>	
What goals would you like to a	chieve from participa	tina in this service?	
<u>Kn</u> e	own Medical Co	ncerns/Conditions	i
Please list any known injuries, troub	le spots, recent surger	ies, or other medical conc	erns and conditions that might
limit your ability to participate in ser	,		_
	<u>Medication</u>	s/Allergies	
Please list any known allergies (envi	ronmental, medicatio	ns, food, etc.)	
Please list current medications inclu	ding over-the-counter	medications prescription	s etc that may affect your
body's response to exercise.	unig over the country.	medications, present the	s, etc. macmay anote year
Medication	Dosa	ge	For What?
		-	



Informed Consent

I,, understand participa	ition in recreation activities and services may have an
element of hazard or inherent danger, and users take full resp Users agree to indemnify and hold harmless the South Suburb and agents for any liability, loss, cost or expense (including att incur while participating in any Parks and Recreation activities	onsibility for their actions and physical condition. oan Parks and Recreation District and its employees torney's fees, medical, ambulance cost) that users may
Before meeting with a South Suburban Parks and Recreation Training program, I certify that I have answered all health and ability. I understand the importance of providing complete anso could lead to possible unnecessary injury to myself during that I may have to provide a medical clearance from my doctorand Recreation personal training or private instruction service	fitness questions honestly and to the best of my ad accurate responses. I recognize that my failure to do fitness testing and/or exercise programs. I understand or prior to participating in any South Suburban Parks
Signature:	Date:
Guardian Signature:	Date:
(Required if participant is under the age of 18)	
Terms and Co	onditions
I agree to adhere to all South Suburban Parks and Recreation policies and procedures.	District's personal training and private instruction
(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 ap hours prior to my scheduled session/appointment. If forfeited, including first time sessions.	propriate Recreation Center or my trainer at least 24 I do not call 24 hours prior, that session will be
If I am late (<15 min), the session will only last until t scheduled. If I am more than 15 minutes late the sch	
Personal training sessions do not expire. Requests for months after the original purchase date. If there is so in personal training, I may submit a request in writing why I can't continue with training sessions. A doctor' requested. SSPRD reserves the right to deny cancella	omething that would prohibit me from participating g to the fitness coordinator with sufficient proof of s note or change of address form may be
If my health status changes after completing the regi understand that I may need to obtain my physician's	istration packet, I will inform my trainer immediately. I 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	ercise	
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 physic 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.	cal activ	vity
also sign this form. I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physic 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	cal activ	vity
also sign this form. I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physic 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.	cal activ	vity

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 Failur Diagnosed Abnormality of Heart Rhythm	e,
	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

2019 PAR-Q+

6.	Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Demention Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndroma.		
	If the above condition(s) is/are present, answer questions 6a-6b		
ба.	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, Pu Blood Pressure	lmonar	y High
	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)	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 condi	tions?	
	If you have other medical conditions, answer questions 10a-10c If NO read the Page 4 re	comme	ndations
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.

2019 PAR-O

- 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 guestions** 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 guestionnaire, 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 guestionnaire. 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-O+ 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.

Public Health Agency of Canada or the BC Ministry of Health Services. 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.

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

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of Health Services. The views expressed herein do not necessarily represent the views of the



Please Do Not Fill Out Unless Requested By Fitness Coordinator

Clinician's Release for Activity

It is my understand participating at a S	ding that South Suburban Recre	(name), may be ation Center in exercise and/or fitness activities.			
		ovider, I am aware of medical condition(s) that and specific guidelines (if needed), are indicated			
<u>Cardiovascular</u>		<u>Strengthening and Flexibility</u> <u>Activities</u>			
o Treadmill		o Legs			
o Upright Stationary	Cycle	o Chest			
o Recumbent Station	nary Cycle	o Upper Back			
o Swimming		o Abdominal			
o Stair Climber		o Lower Back			
o Rowing		o Shoulder			
o Elliptical Trainer		o Arms			
<u>Pilates/Yoga</u>		Amenity o Jacuzzi/Whirlpool o Steam			
Specific comments	regarding limitations o	or contraindications for activity:			
Physician/Medical	Provider Name	Phone Number			
	Trovider Name	Thone Number			
Physician/Medical	Provider Signature	Date			
Please return to: South Suburban Parks and Recreation Douglas H. Buck Community Recreation Center Fitness Coordinator 2004 W. Powers Ave.					

Littleton, CO 80120-1287

Fax: 303-794-9880