



Registration Form

Personalized Fitness Training

**You must be a Student or User Group member to be eligible to sign up for personalized fitness training. Please show proof of membership to the cashier.*

Please check your appropriate university affiliation:

- | | | |
|---|--|--|
| <input type="checkbox"/> ASU Student | <input type="checkbox"/> Athletics Foundation | <input type="checkbox"/> Up and Coming Scholar |
| <input type="checkbox"/> UREC Pass Holder | <input type="checkbox"/> President's Circle | <input type="checkbox"/> Mother and Daughter Academy |
| <input type="checkbox"/> Alumni Association | <input type="checkbox"/> Friends of the Porter Henderson Library | <input type="checkbox"/> F.A.M.E. |

Name: _____

Date: _____

CID #: _____

Please check desired package:

PERSONALIZED FITNESS TRAINING (PFT) PACKAGES	STUDENT RATES	UREC PASS HOLDER RATES	FOUNDATION MEMBER RATES
FITNESS ASSESSMENT (FA) <small>Includes overall fitness and wellness assessment</small>	\$15	\$20	\$25
TRIAL PACKAGE <small>Includes 1 FA and 1 PFT session</small>	\$25	\$30	\$35
START-UP PACKAGE <small>Includes 1 FA and 4 PFT sessions</small>	\$65	\$90	\$115
START-UP "BUDDY" PACKAGE <small>Includes 1 FA and 4 PFT sessions</small>	\$110	\$160	\$210
MAINTENANCE PACKAGE <small>Includes 2 FA (pre and post) and 8 PFT sessions</small>	\$135	\$185	\$230
MAINTENANCE "BUDDY" PACKAGE <small>Includes 2 FA (pre and post) and 8 PFT sessions</small>	\$250	\$350	\$440
PREMIUM PACKAGE <small>Includes 3 FA (pre, periodic, & post) and 17 PFT sessions</small>	\$270	\$370	\$470
PREMIUM "BUDDY" PACKAGE <small>Includes 3 FA (pre, periodic, & post) and 17 PFT sessions</small>	\$520	\$720	\$920
Adult Swim Lessons <small>Includes 4 one hour private sessions</small>	\$100	\$100	\$100

Total Amount: _____

OFFICE USE ONLY:

Patron eligibility
 Form Completed
 Handout Instruction
 UREC INT FEE

Receipt #: _____



Client Information

Personalized Fitness Training

Name	Date	CID
Home Phone	Cell Phone	Email

If registering for swim lessons, please only fill out contact information.

University Affiliation (Check One):	Gender (Check One):	Age:
<input type="checkbox"/> Student <input type="checkbox"/> Faculty	<input type="checkbox"/> Female <input type="checkbox"/> Male	_____
<input type="checkbox"/> Staff <input type="checkbox"/> Foundation _____		

Are you currently exercising? (Check One)

Yes No

If YES...

How long have you been exercising? (Check One)

1-3 Months 3-6 Months
 6-12 Months 12+ Months

What type of exercise do you participate in?
(Check all that apply)

Weight Lifting Yoga/Pilates
 Run/Jog Aerobics
 Walking Biking
 Swimming Other _____

Describe you level of physical activity during the past 4-6 weeks. (Check One)

Very Active (5+ times per week)
 Moderately Active (3-4 times per week)
 Occasionally Active (1-2 times per week)
 Inactive (0 times per week)

How often would you like to exercise per week? (Check One)

1-2/week 3-4/week
 5+/week

If NO...

How long since you last exercised? (Check One)

1-3 Months 3-6 Months
 6-12 Months 12+ Months

What type of exercise have you previously participated in?
(Check all that apply)

Weight Lifting Yoga/Pilates
 Run/Jog Aerobics
 Walking Biking
 Swimming Other _____

How often would you like to exercise per week? (Check One)

1-2/week 3-4/week
 5+/week

What are your fitness goals?

What is your timeline for meeting these goals?

Why is this important to you, and what do you want to change in your lifestyle?



Health Questionnaire

Personalized Fitness Training

Name: _____

Emergency Contact Information

Name: _____

Phone: _____

(include area code)

Regular physical activity is fun and healthy and for most people safe. However, some individuals may have health-related risks that might require them to check with their physician prior to starting an exercise program. To help determine if there is a need for you to see your physician before starting an exercise program, please read the following questions and answer carefully.

All information will be kept in the strictest confidentiality. In addition to the health history questions, we have also listed several questions pertaining to your interests and goals for participating in an exercise/physical activity program.

I. PHYSICAL ACTIVITY SCREENING QUESTIONS

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has your physician ever told you that you have a heart condition? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you experience pain in your chest when you are physically active? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. In the past month, have you experienced chest pain when not performing physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you lose balance because of dizziness or do you ever lose consciousness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have a bone or joint problem that could be aggravated by a change in your level of physical activity? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Is your physician currently prescribing medications for your blood pressure or heart condition? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you know of any other reason why you should not participate in a program of physical activity? |

If you answered yes to any of the above questions, it is recommended that you consult with your physician via phone or in person before having a fitness test or participating in a physical activity program.

II. GENERAL HEALTH HISTORY QUESTIONS

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you ever experienced a stroke? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you have diabetes? If yes, are you currently taking any medications or receiving other treatment related to the diabetes? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you have asthma or another respiratory condition that causes difficulty with breathing? If yes, please describe. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you have any orthopedic conditions that would restrict you in performing physical activity? If yes, please describe. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Have you ever been told by a physician that you have one of the following? (High blood pressure Elevated blood lipids, including cholesterol) |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Do you currently smoke? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Have you experienced within the past 6 months back pain or discomfort that prevented you from carrying out normal daily activities? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Are you currently taking any medications that might impact your ability to safely perform physical activity? |



Release and Indemnity Agreement & Confidentiality Statement

Personalized Fitness Training

Activity: Personalized Fitness Training
Program Area: Fitness
Dates: Ongoing, By Individual Appointment Only
Supervising Organization: ASU University Recreation
Supervisor: Jodi Jackson, Assistant Director of Fitness

In consideration for this service provided by University Recreation (UREC), I, on behalf of myself, my heirs, representatives, executors, administrators, and assigns HEREBY DO RELEASE Angelo State University, its officers, agents, and employees from any cause of action, claims or demands of any nature whatsoever, including but not limited to a claim of negligence, which I, my heirs, representatives, executors and assigns may now have, or have in the future against the University on account of personal injury, property damage, death or accident of any kind, arising out of or in any way related to participation in the Personalized Fitness Training Program.

In consideration of my participation in the Personalized Fitness Training Program, I, the undersigned user, agree to INDEMNIFY AND HOLD HARMLESS Angelo State University, its officers agents, and employees from any and all causes of action, claims, demands, losses or costs of any nature whatsoever arising out of or in any way relating to my participation in the program.

I hereby certify that I have full knowledge of the nature and extent of the risks inherent from participation in the Personalized Fitness Training Program, and that I am voluntarily assuming the risks. I understand that I will be solely responsible for any loss or damage, including death, I sustain while participating and that by this agreement I am relieving the University of any and all liability for such loss, damage, or death.

Please take notice that the actual Personalized Fitness Trainer assigned to you may or may not hold a national Personal Training certificate. However, UREC Personalized Fitness Trainers must successfully complete the UREC In-House Personalized Fitness Trainer course. This course is designed to prepare students physically, academically, and mentally for a future Personal Training National Certification. Please also note that the UREC In-House Personalized Fitness Trainer course is very similar to what is taught in many national Personal Trainer Certification classes.

Confidentiality Clause

All of the above answers will remain confidential between you, your Personalized Fitness Trainer, and the Personalized Fitness Training Program Director. However, your medical/health history may be reviewed by College Administrators. If you have any questions or problems, please review them with your Personalized Fitness Trainer or the Program Director.

I have answered all the above questions about my health history honestly and to the best of my ability and I agree to the release and indemnity policy.

Signature of Participant: _____

Date: _____



Cancellation & Scheduling Policies

Personalized Fitness Training

Activity: Personalized Fitness Training
Program Area: Fitness
Dates: Ongoing, By Individual Appointment Only
Supervising Organization: ASU University Recreation
Supervisor: Jodi Jackson, Assistant Director of Fitness

Congratulations on your recent commitment to your personal well-being. Not only have you made a significant step towards enhancing your overall health, but you are assisting ASU students in their pursuit of experiential knowledge and a future career. Thank you for supporting the Angelo State University community.

The Assistant Director of Fitness and/or your Personalized Fitness Trainer will contact you within the next three business days to schedule your first appointment. The phone numbers listed on your "Client Information" form will be used to contact you.

To reschedule an appointment, clients must notify their Personalized Fitness Trainer or the Assistant Director of Fitness at least 24 hours in advance. If the client fails to do so, the fee for that session will be forfeited.

Please note that all Personalized Training Sessions purchased are valid until the end date of the semester in which they were purchased. Your sessions will remain valid until 06/01/2018. Upon the passing of this date these sessions will then become null and void.

In keeping with the spirit of student development, participant safety, and quality programming: **NO PERSONALIZED FITNESS TRAINING SESSIONS MAY TAKE PLACE DURING UNIVERSITY HOLIDAYS AND BREAKS.** This practice is largely due to reduced facility hours of operation and limited staffing availability. Thank you for your understanding.

All sales are final, and there will be no refunds.

I have read, understood, and agreed to the conditions stated above.

Signature of Participant: _____

Date: _____



Client Availability

Personalized Fitness Training

Please mark out/cross out any time below when you are NOT available to meet with a trainer.

	MON	TUE	WED	THU	FRI	SAT	SUN
7:30 am-8:00 am							
8:00 am-8:30 am							
8:30 am-9:00 am							
9:00 am-9:30 am							
9:30 am-10:00 am							
10:00 am-10:30 am							
10:30 am-11:00 am							
11:00 am-11:30 am							
11:30 am-12:00 pm							
12:00 pm-12:30 pm							
12:30 pm-1:00 pm							
1:00 pm-1:30 pm							
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7:30 pm-8:00 pm							
8:00 pm-8:30 pm							
8:30 pm-9:00 pm							
9:00 pm-9:30 pm							
9:30 pm-10:00 pm							
10:00 pm-10:30 pm							
10:30 pm-11:00 pm							
11:00 pm-11:30 pm							
11:30 pm-12:00 am							

Please list below the specific days and/or times you would like to meet with your trainer:

PARTICIPANT INSTRUCTIONS

Explicit instructions for participants before exercise testing increase test validity and data accuracy. Whenever possible, written instructions along with a description of the evaluation should be provided well in advance of the appointment so the client or patient can prepare adequately. The following points should be considered for inclusion in such preliminary instructions; however, specific instructions vary with test type and purpose.

- Participants should refrain from ingesting food, alcohol, or caffeine or using tobacco products within 3 hours of testing.
- Participants should be rested for the assessment, avoiding significant exertion or exercise on the day of the assessment.
- Clothing should permit freedom of movement and include walking or running shoes. Women should bring a loose-fitting, short-sleeved blouse that buttons down the front and should avoid restrictive undergarments.
- If the evaluation is on an outpatient basis, participants should be made aware that the evaluation may be fatiguing and that they may wish to have someone accompany them to the assessment to drive home afterward.
- If the test is for diagnostic purposes, it may be helpful for patients to discontinue prescribed cardiovascular medications, but only with physician approval. Currently prescribed antianginal agents alter the hemodynamic response to exercise and significantly reduce the sensitivity of ECG changes for ischemia. Patients taking intermediate or high-dose β -blocking agents may be asked to taper their medication over a two-to-four-day period to minimize hyperadrenergic withdrawal responses.
- If the test is for functional or exercise prescription purposes, *patients should continue their medication regimen* on their usual schedule so that the exercise responses will be consistent with responses expected during exercise training.
- Participants should bring a list of their medications, including dosage and frequency of administration, to the assessment and should report the last actual dose taken. As an alternative, participants may wish to bring their medications with them for the exercise testing staff to record.
- Drink ample fluids over the 24-hour period preceding the test to ensure normal hydration before testing.
- Swim participants will need to bring proper swim attire to each session.

American College of Sports Medicine. *ACSM's Guidelines for Exercise Testing and Prescription*, 8th ed. Baltimore: Lippincott Williams & Wilkins; 2010. 57-58.