Please attach participant receipt to packet. All participants must complete packet prior to the start of Program.

University Recreation Small Group Training Registration

General Information

Small Group Training classes utilizes a variety of functional fitness equipment in a challenging and fun environment. The UREC certified personal training staff will take you on the ultimate fitness experience while providing you with motivation, tips and progression toward your goals.

UREC RazorFitness is a six-week small group training program. Each week builds on the progress made in earlier sessions with exercises designed to improve muscular strength, muscular endurance, agility, and cardiovascular endurance. Throughout the program, workouts will deliver varying degrees of intensity, starting with a dynamic warmup and peaking with high-intensity agility and strength exercises utilizing a variety of equipment including TRX Suspension system, ViPR's and TRX Rip trainers. Each UREC RazorFitness team is made up of 6 participants, creating a friendly and motivational workout environment.

Price: Student members ($43), UREC members ($57)

Registration

Payment must be received at the time of registration. Participants must have all portions of packet completed and emailed to fitness@uark.edu . A Physician clearance form may be required for participants who check "yes" for any listed conditions.

Name: _____ Date of Birth:_____

Phone: _____ Email:_____

Participation Agreement

I understand the following refund policies of the University Recreation Personal Training program:

All sessions must be used within 6 months of purchase. Sessions held 6 months after purchase will become void. Any sessions that remain unused for any reason will not be refunded. Cancellations not made 24-hours in advance of the scheduled session will be forfeited by the client. UREC does not refund for programs affected by restricted parking. For parking information, please visit http://parking.uark.edu/.

_____ (Initial)

Health History Disclosure

Height: _____ Weight: _____

Have you or an immediate family member, now or in the past experienced: *Check all that apply.*

You	Family		You	Family	
_____		Chest Pain	_____		Asthma
_____		Heart Attack	_____		Bursitis
_____		Heart Disease	_____		Arthritis
_____		Pacemaker	_____		Tendonitis
_____		High Blood Pressure (>140/90)	_____		Muscle Injury
_____		Diabetes mellitus	_____		Joint Injury
_____		Cancer	_____		Smoking
_____		Currently pregnant/postpartum	_____		Dizziness
_____		Depression	_____		Osteoporosis
_____		Low Back Pain	_____		High Cholesterol (>200)
_____		Nutrition Related Disorder			

If you have checked any above, please explain below:

List all medications you are currently taking:

When exercising, do you feel any of the following?

_____ Chest pain

_____ Leg aches

_____ Shortness of breath

_____ Dizziness

_____ General fatigue

_____ Pressure over the heart

In case of emergency, please contact:

Name_____ Relationship_____

Phone (Home)_____ (Work)_____

(Cell)_____

Part IV: Release of Liability

In consideration of being permitted to participate in fitness programs and personal training sessions, which may consist of warm-up, flexibility activities, cardio respiratory activities, muscular strength and endurance activities, and fitness assessments: I have volunteered to participate in a program of progressive physical exercise. I waive any possibility of personal damage which may be blamed upon such a program in the future and accept the responsibility for accepting such exercise and assistance.

_____ (Initials)

There exists the possibility of certain physiological changes during the program. These include elevated heart rate, muscle or joint pain, abnormal blood pressure, fainting, irregular, fast, or slow heart rhythm, and in rare instances, heart attack, stroke, or death. I hereby acknowledge and accept these risks. Information that I provide about my health status or previous experiences of heart-related symptoms with physical effort may affect the safety of this program. I accept responsibility for fully disclosing my medical history, as well as symptoms that may occur during the program. To my knowledge, I do not have any limiting physical condition or disability which would preclude an exercise program. I understand that I am responsible for monitoring my own condition throughout exercising, and should any unusual symptoms occur, I will cease my participation and inform the trainer of the symptoms. Unusual symptoms include, but are not limited to the following: chest discomfort, nausea, difficulty in breathing, and joint or muscle pain or strains.

_____(Initials)

An examination by a physician should be obtained by all participants prior to involvement in an exercise program. If a participant refuses to obtain a physician's consent, he/she must sign the following statement:

I, _____, have been informed of the need for a physician's approval for participation in a progressive exercise and fitness program. I fully understand the strenuous nature of the program and accept complete responsibility for my health and well-being in the voluntary exercise and fitness program and related testing.

_____(Initials)

Other risks of participation in Fitness/Wellness classes and programs include, but are not limited to: trips, falls, collisions, sprains, strains, cuts, bruises, lacerations, broken bones. I understand that the risks and dangers of participation are real. I am still interested in participating and will hold harmless for ordinary negligence the University, its instructors, all employees, the University Recreation Department, and any volunteers involved in this program. I agree that I, my heirs, or any family member will not hold the University negligent for any injuries that may occur during any part of the program. For the right to participate in this program, I freely sign away my rights to sue for negligence.

Participant's Signature_____ Date:_____

The following questions assist your trainer in preparing and monitoring fitness goals. Please answer to the best of your ability and ask your trainer any questions that you may have.

Height: _____ Weight: _____

1. Do you have any negative feelings toward or have you had any bad experiences with physical activity programs?

2. Do you have any negative feelings toward or have you had any bad experiences with fitness testing and evaluation?

3. Rate yourself on a scale of 1 to 5, with 1 indicating the lowest value and 5 the highest. Circle the number most applicable for you.

   Characterize your present athletic ability:
   1 2 3 4 5
   Characterize your present cardiovascular capacity:
   1 2 3 4 5
   Characterize your present muscular capacity:
   1 2 3 4 5
   Characterize your present level of flexibility:
   1 2 3 4 5

4. Are you currently involved in regular exercise?
   Yes _____ No _____ If yes, what type of exercise? _____

5. What types of activities interest you?

6. What barriers do you think have prevented you in the past from beginning or adhering to an exercise program?

7. Rank your goals 1 to 10, where 1 is the most important to you:

Improve cardiovascular fitness	_____	Gain weight	_____
Reduce body fat level	_____	Enjoyment	_____
Reshape or tone body	_____	Increase strength	_____
Improve flexibility	_____	Increase energy level	_____
Lose weight	_____	Other (please explain)	_____

Medical Clearance Form (if necessary)

Dear Physician: Date ____/____/____

Your patient, _____, has applied to participate in one-on one personal training with the University of Arkansas University Recreation Department, which requires your medical clearance 1) due to the "yes" response on the Health History Disclosure and/or 2) the individual is a member of a special population needing additional clearance to begin an exercise program.

Your patient will be involved in an exercise program that will be based on the ACSM's standards for exercise. He/she will be participating in cardiovascular exercise, strength training, and flexibility exercises during their exercise appointments.

Please indicate below if you approve of your patient's participation in our one-on-one personal training program. Thank you.

_____ I know of no reason why the applicant may not participate.

_____ I believe the applicant may participate, but I urge caution because:

_____

_____ The applicant should not engage in the following activities:

_____

_____ I recommend that the applicant NOT participate.

Physician signature_____

Physician name printed_____ Date____/____/____

Address _____

Phone _____-_____-_____

Please return by email or fax to
Casey Fant: cfant@uark.edu

Address:
HPER 225
155 N. Stadium Dr
Fayetteville, AR 72701

Phone:
479-575-3542