

Summer 2021  
Small Group Training  
Registration



**Name:** \_\_\_\_\_

**Days/Time:** \_\_\_\_\_

# Small Group Training Information Packet

## General Information

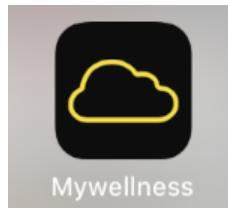
**Session Dates: Session 1: May 24th-June 28th | Session 2: July 12th- August 12th**

**Note: Classes will not run during University holidays.**

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

Additionally, UREC is partnering with Technogym to allow for an interactive fitness experience.

Please download the mywellness app in order to have the most seamless use of this service:



Once your registration packet has been received and processed you will receive an invite to create an account with Technogym and be a part of the University of Arkansas page.

**UREC RazorFitness** is a five-week small group training program. Each week builds on the progress made in earlier sessions with exercises designed to improve agility, functional strength, power, and muscular strength. 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 eight participants, creating a friendly and motivational workout environment.

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

## Registration Form

**Payment must be received at the time of registration. Participants must have all portions of packet completed. Physician clearance form may be required for participants who check "yes" for any listed conditions.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Section Offerings (check one):**

**Monday, May 24th- Thursday, June 28th (five weeks)**

Monday	Tuesday	Wednesday	Thursday
<b>RazorFitness</b> UREC Train 12-12:50pm Aryn	<b>RazorFitness</b> UREC Train 12-12:50pm Katherine	<b>RazorFitness</b> UREC Train 12-12:50pm Aryn	<b>RazorFitness</b> UREC Train 12-12:50pm Katherine
<b>RazorFitness</b> UREC Train 5:30-6:20pm Jonathan		<b>RazorFitness</b> UREC Train 5:30-6:20pm Jonathan	
	<b>RazorFitness</b> UREC Train 6:45-7:35pm Aryn		<b>RazorFitness</b> UREC Train 6:45-7:35pm Aryn

**UREC RazorFitness:**

**Tuesday/Thursday 12:-12:50pm**

\$43 Student Members

\$57 UREC Members

**UREC RazorFitness: Tuesday/**

**Thursday 6:45-:7:35pm**

\$43 Student Members

\$57 UREC Members

**UREC RazorFitness:**

**Monday/Wednesday 12-12:50pm**

\_\_\_ \$43 Student members \_\_\_ \$57 UREC members

**UREC RazorFitness:**

**Monday/Wednesday 5:30-6:20pm**

\_\_\_ \$43 Student members \_\_\_ \$57 UREC members

## Part II: Participation Agreement

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

I understand that full payment is due upon registration. I recognize that services are non-refundable, non-transferable, and expire at the end of the semester in which services were purchased. I agree to adhere to all UREC Small Group Training policies and procedures. UREC does not refund for programs affected by restricted parking. For parking information, please visit <http://parking.uark.edu/>.

\_\_\_\_\_ (Initial)

## Part III: Health History Disclosure

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

<b>You</b>	<b>Family</b>		<b>You</b>	<b>Family</b>	
_____	_____	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 (total > 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: \_\_\_\_\_

## Part V: Personal Fitness Evaluation

The following questions assist your coach 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)	_____

**Part VI: Medical Clearance Form (if necessary)**

Dear Physician:

Date \_\_\_/\_\_\_/\_\_\_

Your patient, \_\_\_\_\_, has applied to participate in small group 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 Aryn Chambliss: atchambl@uark.edu  
Address: HPER 225  
155 N. Stadium Dr.  
Fayetteville, AR 72701  
Fax: 479-575-7008 (F)  
479-575-3542 (P)



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**ARKANSAS**  
COLLEGE OF EDUCATION  
& HEALTH PROFESSIONS  
UNIVERSITY RECREATION

