Summer 2022

Small Group Training

UREC®
University Recreation

Small Group Training classes utilize 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.

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, power, endurance, cardiovascular endurance, and agility. Throughout the program, workouts will deliver varying degrees of intensity, starting with a dynamic warmup and finishing with high intensity strength and agility exercises. RazorFitness utilizes a variety of equipment including kettlebells, TRX Suspension Trainers, and ViPR's. Each RazorFitness team is made up of up to 4 participants, creating a fitness community for participants to grow with during the 6-week session.

Name: _____

Date of Birth: _____

Email: _____

Phone Number (optional): _____

Price: Students ($43), Members ($57)

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.

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.*

You	Family	
_____	_____	Chest Pain
_____	_____	Heart Attack
_____	_____	Heart Disease
_____	_____	Pacemaker
_____	_____	High blood pressure (>140/90)
_____	_____	Diabetes mellitus
_____	_____	Cancer
_____	_____	Currently pregnant/postpartum
_____	_____	Depression
_____	_____	Low back pain
_____	_____	Nutrition related disorder

You	Family	
_____	_____	Asthma
_____		Bursitis
_____		Arthritis
_____		Tendonitis
_____		Muscle Injury
_____		Joint injury
_____		Smoking
_____		Dizziness
_____		Osteoporosis
_____		High Cholesterol (total > 200)

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
Jordan Stroope: jstroope@uark.edu

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

Phone:
479-575-6080

UNIVERSITY OF ARKANSAS
COLLEGE OF EDUCATION & HEALTH PROFESSIONS
UNIVERSITY RECREATION