Spelman College

Department of Campus Wellness

Personal Training Packet

Please note that after your paperwork has been processed, you will be contacted via email within 24-48 hours to schedule an assessment. Everyone is required to complete an assessment prior to training.

If you do not receive an email from wellnesscenter@spelman.edu, please contact the front desk at (404) 270-6086.

This is small group personalized training. A maximum of ten **(10)** students will be allowed per session. You must sign-in upon arrival. When the max is reached, you will have to sign-up for the next available session. All personal training sessions are 45 minutes.

PAR-Q & Medical Clearance Form: A medical clearance form is required of all participants who answer 'yes' to any of the PAR-Q questions. Personal training staff reserve the right to require medical clearance from any client they feel may be at risk.

Gym Attire: Wearing the right workout clothes can help you stay comfortable and cool during exercise. Gym clothing should be loose, but not "flowing". Wear clothes that hug the body without constricting your motion. In general, keep in mind that you don't want any clothing that gets in the way of the activity.

Appropriate Footwear: Bring shoes that will offer plenty of protection for your feet and legs. Keep in mind that we do not allow open-toed shoes and crocs.

Late Policy: Please arrive on time to your training sessions. Trainers are only obligated to wait 15 minutes for 45-minute sessions. If you are late, your session will end at the time scheduled.

REGISTRATION

Thank you for expressing interest in our Small Group Personalized Training Program. Please complete the registration form and email to wellnesscenter@spelman.edu All Forms are for personal training staff only and is kept confidential.

If you are not able to complete electronically, please print this packet, fill it out entirely and turn in at the wellness center front desk. Please write legibly and in print.

NOTE: Deadline to submit registration form electronically or in-person is Friday, Oct. 8.

Name: _____

Email: _____ Phone: _____

Circle a day and time below that you are available to complete your 15 min assessment. This is also the current schedule for personal training.

Assessment/Training Schedule	Availability	Availability
Tuesday	11:00am 12:00pm	4:00pm 5:00pm
Thursday	11:00am 12:00pm	4:00pm 5:00pm
Friday	11:00am 12:00pm	1:00pm 2:00pm

By printing your name below, you are acknowledging that you have read and agree to the terms and policies of the Department of Campus Wellness Small Group Personalized Training Program. In addition, you attest that you have answered the Health History and PAR-Q truthfully and to the best of your knowledge.

You agree to submit the completed Medical Clearance Form to the Personal Training staff if you answered 'Yes' to any of the PAR-Q questions. You acknowledge that the PAR-Q is valid for a maximum of 12 months from the date it is completed and become invalid if your condition changes, at which point you must submit an updated PAR-Q to the Personal Training staff.

You understand that all forms must be submitted before scheduling can occur, which includes the Medical Clearance Form, if applicable.

Print Name: _____ Date: _____

PAR-Q

Regular physical activity is fun and healthy, and more people should become more physically active every day of the week. Being more physically active is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from a doctor before becoming more physically active.

Please read the seven questions below carefully and answer each one honestly: check YES or NO.

QUESTION	YES	NO
Has your doctor ever said that you have a heart condition OR high blood pressure?		
Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?		
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 vigorous exercise).		
Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?		
Are you currently taking prescribed medications for a chronic medical condition?		
Do you have a bone or joint problem that could be made worse by becoming more physically active? Please answer NO if you had a joint problem in the past, but it does not limit your current ability to be physically active. For example: knee, ankle, shoulder or other.		
Has your Primary Care Provider ever said that you should only do medically supervised physical activity?		

If you answered NO to all of the questions above, you may proceed with personal training.

If you answered YES to one or more of the questions above, a medical clearance form is required. Discuss with your primary care physician any conditions that might affect your exercise program. All precautions must be documented on the medical clearance form by your primary care physician. *If in doubt after completing the PAR-Q, consult with your personal doctor prior to physical activity.*

NOTE: Personal training staff reserve the right to require medical clearance from any client they deem may be at risk.

HEALTH HISTORY

Complete the **NINE** questions below and input answers in the space provided.

Date: _____ Name: _____

Gender: _____ Age: _____ DOB: _____/_____/_____

CHECK YES OR NO	YES	NO
1. Do you have an ongoing health complication or chronic illness?		
2. Have you had high blood pressure or high cholesterol?		
3. Have you ever had a head injury, concussion, or seizure?		
4. Do you have a diabetes or thyroid condition?		
5. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler?		
6. Have you had a recent (less than 12 months) surgery?		
7. Have you had any problems with pain or swelling in muscles, tendons, or joints? If yes, please list the muscle/tendon/joint.		
8. Are you currently pregnant?		
9. Have you given birth within the past year?		

OFFICE USE ONLY

General Physiological Information

Height_____Feet____Inches

Weight _____lbs

Blood Pressure_____mmHg

RHR_____HRmax___

THR 60%__

THR 70%__

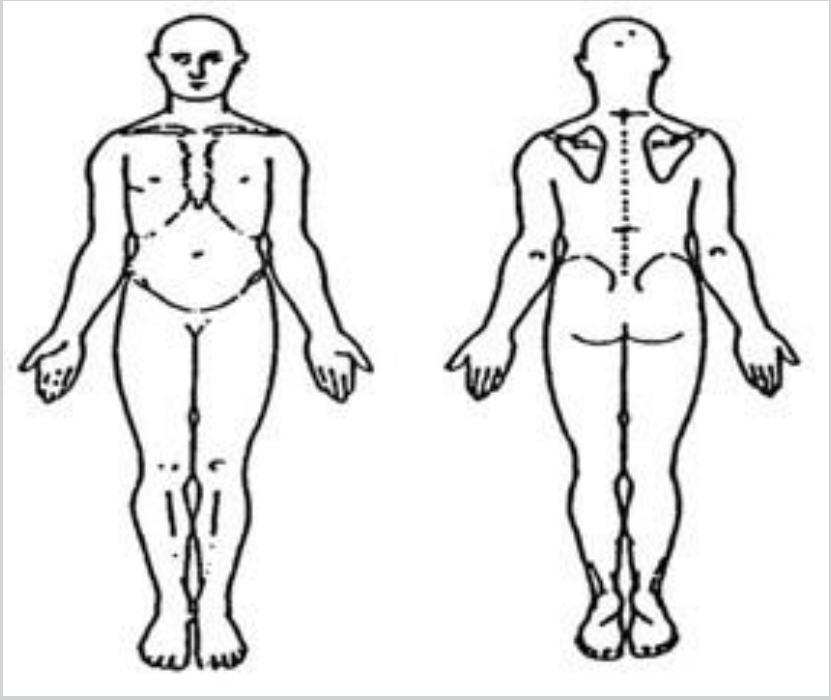
THR 80%__

Body Composition

Chest/Triceps_____

Ab/Illiac _____Thigh____

Total_____ BF%____



LIABILITY & RISK AGREEMENT

I acknowledge that participating in personal training is a dangerous activity. I realize that the inherent risks of participating in a personal training program include injuries due to equipment failure, bad decision-making, and my underlying physical and mental condition. I understand that unforeseeable accidents occur and I assume all risks associated with such accidents, even though I nor the Spelman Wellness staff cannot foresee them.

I agree to pay attention to the condition of all equipment and to advise the facility staff if I do any damage or notice any damage. I agree to abide by all Wellness Center rules, and if the facility staff makes a specific request of or instruction to me, I agree to comply.

I certify that I am physically capable of participating in personal training activities and have informed the staff of any medical or health conditions I have that may affect these activities. I agree to supply a doctor's note (Medical Clearance Form) should I have experienced any of the following conditions: chest pain while exercising, chest pain while not exercising, loss of balance because of dizziness, loss of consciousness, bone or joint problem that could worsen as a result of physical activity, prescribed medication for blood pressure or heart condition, doctor's indication of a heart condition, or any other reason why I should not partake in physical activity. In addition, I agree to inform the staff of any changes in my medical or health condition while a participant in this program.

I give permission for the facility staff to seek emergency medical services for me should I become injured or ill with the understanding that I am responsible for any expenses incurred. I fully understand that Spelman College does not provide any medical insurance coverage for me while participating in this facility or offsite.

I agree to assume all risk of personal injury, medical expenses, and property damages and loss incurred while participating at Spelman College in the Department of Campus Wellness at Read Hall, Small Group Personalized Training Program.

I have carefully read and acknowledge this agreement. I fully understand its contents and have decided to provide my signature at my will.

Signature: _____ Date: _____

If participant is a minor under 18 years old, a Parent Consent Form must also be signed and submitted by parent or legal guardian.

Printed Name: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: _____

MEDICAL CLEARANCE FORM

Dear Primary Care Physician:

_____wishes to start a small group personalized training program with the Department of Campus Wellness at Spelman College. The Personal Training packet includes a health screening (body composition analysis; manual blood pressure measurement; resting heart rate measurement; height/weight measurements), a consultation, and on-the-floor training. The exercise program is designed to start at a comfortable level and become progressively challenging over a period of time. Both cardiovascular exercise and strength training will be a part of the client's program. All exercise screening and exercise programs will be administered by personal trainers trained in conducting exercise screenings and develop exercise programs.

By completing the form below, you are not assuming any responsibility for our administration of the exercise screening and/or exercise programs. If you know of any medical or other reasons why participation in the exercise screening and/or exercise programs by the applicant would be unwise, please indicate so on this form.

If you have any questions about the Department of Campus Wellness exercise screening procedures and/or exercise programs, please call our office at (404) 270 -6086.

This form can be faxed to (404) 270-5714.

Please record response to this letter by initialing.

_____ I do not know of any reason that would deem student ineligible to participate.

_____ I believe the student can participate, but I urge caution due to the findings below:

_____

_____ The student should not engage in following activities:

_____

_____ I recommend the applicant NOT participate.

Physician's signature _____ Date_____

Name of Clinic and Address _____

Phone_____