RAM Training

Fitness Assessment & Consultation

What is a fitness assessment and why do I need one?

In a Fitness Assessment, the five components of physical fitness – body composition, cardiovascular endurance, muscular endurance, muscular strength, and flexibility – will be assessed and results will be categorized based on age and gender. Fitness assessments assess baseline levels of fitness and identify strengths and weaknesses, allowing you or your trainer to make a better program tailored for you or to track your progress.

In a Fitness Consultation, a personal trainer will provide an individual exercise prescription based on the results of the Fitness Assessment to meet the goals of the client. It will provide a well-rounded plan that will include cardio, strength, and flexibility exercises to help you get jump started to a healthy balanced lifestyle.

Cost: $15

Appointment Information

Pick up a Fitness Assessment & Consultation form at the WCU Campus Recreation Center Welcome Desk or download it from our website at www.wcupa.edu/campusrec. At this time, if the client does not request a Personal Trainer on the questionnaire sheet and the client has no preference, a Personal Trainer will be assigned based on availability.

A Personal Trainer will then contact you to set up your first appointment within 72 hours of submitting your form (as long as medical clearance is not needed). It's that easy!

Payment Policy

Payment must be made upon submission of registration materials. Methods of payment include **cash or check only.** Please make checks payable to West Chester University. Paying a personal trainer directly is prohibited and will result in having all membership privileges terminated immediately.

Late Policy

Please arrive for your appointment on time. Patrons that arrive 15 or more minutes late for an appointment will forfeit the appointment and not receive a refund.

Cancellation Policy:

If you must cancel a Fitness Assessment appointment, please contact the Personal Trainer at least 24 hours in advance of the scheduled appointment. You will be charged for appointments cancelled with less than 24 hours' notice.

RAM Fitness Assessment and Consultation Interest and Availability Form

Name: ____ Date: __________________________

E-Mail: ____ Phone: _________________________

West Chester Affiliation: STUDENT FACULTY/STAFF AFFILIATE

Do you prefer a male or female personal trainer? _________________________________

Request personal trainer by name: ____

Please list all days & times you are available for your Fitness Assessment and Consultation:

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Health Status Questionnaire

This questionnaire identifies adults for whom physical activity might be inappropriate or adults who should seek physician consultation before beginning a regular physical activity program.

Section 1 (Personal and Emergency Information)

Name: ____________________
Date of birth: ____________________
Address: ____________________
Phone: ____________________
Physicians name: ____________________
Height: ____________________ (inches)
Weight: ____________________ (lbs)

Person to contact in case of emergency:
Name: ____________________
Phone: ____________________

Section 2 (General Medical History)

Please check the following conditions that you have experienced

Heart history:
Heart attack___
Heart surgery___
Cardiac catheterization___
Coronary angioplasty (PTCA)___
Cardiac pacemaker___
cardiac rhythm disturbance___
heart valve disease___
heart failure___
heart transplantation___
congenital heart disease___

Symptoms:
You experience chest discomfort with exertion___
You experience unreasonable shortness of breath at any time___
You experience dizziness, fainting, or blackouts___
You take heart medications___

Additional health issues:
You have asthma or other lung diseases (e.g., emphysema)___
You have burning or cramping sensations in your lower legs with minimal physical activity___
You have joint problems (e.g., arthritis) that limit your physical activity___
You have concerns about the safety of exercise___
You take prescription medication___
You are pregnant___

Section 3 (Risk Factor Assessment)

Risk factors for coronary heart disease:
You are a man older than 45 years___
You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal___
You have diabetes (type 1 or 2)___
You smoke or you quit smoking within the previous 6 months___
Your blood pressure is >140/90 mmhg___
Your cholesterol is >200 mg . dl-1___
You have a close blood relative (father or brother) who had a heart attack or heart surgery before the age of 55 or a close female relative (mother or sister) who had a heart attack or heart surgery before the age of 65___
You are physically inactive (you get less than 30 minutes of physical activity at least 3 days per week)___
Your waist circumference is greater than 40 in. (101.6cm in men) or greater than 35 in. (88.9 cm in women)___

Section 4 (Medications)

Are you currently taking any medications?
Yes___
No___

If yes, please list all of your prescribed medications and how often you take them, whether daily (D) or as needed (PRN).

Of the medications you have listed, are there any you do not take as prescribed?

Section 5 (Physical Activity Patterns and Objectives)

List the type, frequency, intensity (e.g., low, moderate, strenuous), and duration of your weekly exercise:

List your specific goals for your exercise program:

****If you have answered yes to questions indicating that you have significant cardiac, pulmonary, metabolic, or orthopedic problems that may be exacerbated with exercise, you MUST have medical clearance prior to exercising.****

Patient information release form

I understand the purpose of this Health History Questionnaire and I acknowledge that the staff of the Center will be relying on the accuracy and completeness of the information I have provided. I am aware that any strenuous physical activity involves risk, and I fully accept those risks. In consideration of the opportunity to participate in activities at the Center, I voluntarily remise, release and forever discharge West Chester University, its successors, assigns, trustees, officers, students, employees and agents from any and all personal injuries, damages, losses, claims, causes of action, or lawsuits of any kind whatsoever suffered by me as a result of my participation in any and all activities that I might undertake at the Center, including, without limitation, my fitness assessment.

By signing below, I am also consenting to first-aid, emergency medical care and, if necessary, admission to an accredited hospital or an emergency care center selected by staff at the WCU Recreation Center or emergency response personnel if necessary for the provision of such care, for treatment of injuries that I may sustain while participating in activities at the Center. I understand and agree that I will be responsible for all expenses incurred in connection with any such first-aid, emergency medical care, including, without limitation, any and all expenses that may be associated with my transportation and admission to a hospital or emergency care center. I acknowledge and agree that my consent to medical care and my financial responsibility for such care is not conditioned on communication with the emergency contact identified above, or on confirmation of coverage of my medical insurance for such medical care.

I declare, to the best of my knowledge, that all my answers are true, correct, and complete.

By signing this Health History Questionnaire and Release, I hereby certify that I am 18 years of age or older and that I have read and fully understand the conditions herein provided.

Signature: _____________________________ Date: __________

Personal Trainer signature: _________________________ Date: __________

Informed Consent for Participation Personal Training Program

Purpose and explanation of procedure

I hereby consent to voluntarily engage in an acceptable plan of personal fitness training. I also give consent to be placed in personal fitness training program activities that are recommended to me for improvement of my general health and well-being. These may include general dietary counseling, stress management, and health/fitness education activities. The levels of exercise I perform will be based upon my cardio respiratory (heart and lungs) and muscular fitness. I understand that I may be required to undergo a graded exercise test as well as other fitness tests prior to the start of my personal fitness training program in order to evaluate and assess my present level of fitness. I will be given exact personal instructions regarding the amount and kind of exercise I should do. I agree to participate in a predetermined number of a formal program sessions (guided and unguided). Professionally trained personal fitness trainers will provide leadership to direct my education and activities, monitor my progression, and otherwise evaluate my effort. Depending upon my health status, I may or may not be required to have my blood pressure and heart rate evaluated during these sessions to regulate my exercise within desired limits. I understand that I am expected to attend every session and to follow staff instructions with regard to exercise, diet, stress management, and other health/fitness related programs. If I am taking prescribed medication, I have already so informed the program staff and further agree to so inform them promptly of any changes my doctor or I make with regard to the use of these. I will be given the opportunity for periodic assessment and evaluation at regular intervals after the start of my program.

I have been informed that during my participation in this personal fitness training program, I will be asked to complete the physical activities unless symptoms such as fatigue, shortness of breath, chest discomfort, or similar occurrences appear. At that point, I have been advised that it is my complete right to decrease or stop exercise and that it is my obligation to inform the personal fitness training program personnel of my symptoms. I hereby state that I have been so advised and agree to inform the personal fitness training program personnel of my symptoms, should any develop.

I also understand that during the performance of my personal fitness training program, physical touching and positioning of my body may be necessary to assess my muscular and bodily reactions to specific exercises, as well as ensure that I am using proper technique and body alignment. I expressly consent to the physical contact for these reasons.

Risks

I understand and have been informed that there exists the remote possibility of adverse changes accruing during exercise including, but not limited to, abnormal blood pressure, fainting, dizziness, disorders of heart rhythm, and very rare instances of heart attack, stroke, or even death. I further understand and have been informed that there exists the risk of bodily injury including, but not limited to, injuries to the muscles, ligaments, tendons, and joints of the body. I have been told that every effort will be made to minimize these occurrences by proper staff assessments of my condition before each exercise session, by staff during exercise, and by my own careful control of exercise efforts. I fully understand the risk of bodily injury, heart attack, stroke, or even death, but knowing these risks, it is my desire to participate as herein indicated.

Testing and Evaluation Results

I understand that I will undergo initial testing to determine my current physical fitness status. The testing will consist of some or all of the following: Body composition, Cardiovascular fitness, Muscular fitness and Flexibility.

I understand that the fitness evaluation will be used to baseline my current level of fitness and to highlight any specific needs. It will also be used to design a customized fitness program for me. I understand that my fitness evaluation does not include a personalized workout. It will include, in addition to the baseline

fitness assessment, fitness education, general nutritional evaluation, review of health and exercise history and goal setting.

I further understand that such screening is intended to provide the Department of Campus Recreation with essential information used in the development of individual fitness programs. I understand that my individual results will be made available only to me. I also understand that the testing is not intended to replace any other medical test or the services of my physician.

I understand that I am responsible for informing the Department of Campus Recreation if there are any changes in my health or physical condition.

Benefits to be expected & available alternative to exercise

I understand that this program may or may not benefit my physical fitness or general health. I recognize that involvement in the exercise sessions and personal fitness training sessions will allow me to learn proper ways to perform conditioning exercises, use of fitness equipment, and regulate physical effort. These experiences should benefit me by indicating how my physical limitations may affect my ability to perform various physical activities. I further understand that if I closely follow the program's instructions, I will likely improve my exercise capacity and fitness level after a period of 3 to 6 months

Confidentiality and use of information

I have been informed that the information obtained in this personal fitness training program will be treated as privileged and confidential and will consequently not be released or revealed to any person without my express written consent. I do, however, agree to the use of any information that is not personally identifiable with me for research and statistical purposes so long as it does not identify me or provide facts that could lead to my identification. I also agree to the use of any information for the purposes of consultation with other health/fitness professionals, including my doctor. Any other information obtained, however, will be used by the program staff in the course of prescribing exercise for me and evaluating my progress in the program.

I further understand that there are also other remote risks that may be associated with this personal fitness training program. Despite the fact that a complete accounting of all these remote risks has not been provided to me, it is still my desire to participate.

I agree to indemnify and hold harmless the University, PASSHE, the State System of Higher Education, its Trustees, officers, agents and employees of the sport club program, from and against any and all claims, liability, losses, third party claims, damages, costs, or expenses (including attorneys' fees), from any responsibility or liability in case of personal injury sustained by me or damage to property of others caused by me during or because of participation in the activities of a personal training program

I acknowledge that I have read this document in its entirety or that it has been read to me if I have been unable to read same.

I expressly consent to the rendition of all services and procedures as explained herein by all program personnel.

______________________________ ______________________________

Participants signature | Date

______________________________ ______________________________

Personal Trainer Signature | Date

Physicians Consent Form

(If Applicable)

Dear Dr. ______________________________

Your patient: _______________________________ would like to begin an exercise program at ______________________________ (Student Recreation Center at West Chester University). After reviewing ______________________________’s (patient’s name) responses to our health status questionnaire, we would appreciate your medical opinion and recommendations concerning participation in regular exercise. Please provide the following information and return this form to

______________________________ (name)

______________________________ (address)

______________________________ (phone/fax)

1. Are there specific concerns or conditions our staff should be aware of before this individual engages in regular exercise at our facility? Yes/No, if yes, please specify.

____

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2. If this individual has completed a graded exercise test, please provide the following:

a. Date of test ____________________

b. A copy of the final exercise test report and interpretation

c. Your specific recommendations for exercise training, including heart rate limits during exercise:

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3. Please provide the following information so that we may contact you if we have any further questions:

__________ I AGREE to the participation of this individual in regular exercise activity at your facility.

__________ I DO NOT AGREE that this individual is a candidate for exercise at your facility, and this individual should be referred to a supervised exercise facility because

____

____

Physician’s signature ______________________________

Physician’s name ______________________________

Address ______________________________

Thank you for your consideration.

Signature of Personal Trainer ______________________________