

# Fitness Registration Packet

Note: Pages 1-3 are required of everyone. Follow instructions on page 3 to see if page 4 is required for you. Turn in packets to the SIRA Office (CJR 214) or Derek Timourian in CJR 158A.



(Please Print)

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

**Gender:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone(s):** \_\_\_\_\_

\_\_\_\_\_ **Email:** \_\_\_\_\_

**SU Affiliation:** STUDENT / FACULTY / STAFF / ALUMNI / RETIREE / SPOUSE / PUBLIC  
(Circle One)

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone numbers for Contact:** \_\_\_\_\_

**Doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Program:** Aqua Fitness / Cardio Training / Circuit Mania / Morning Stretch /  
(Circle One) Pilates / Tango / Ultimate Fitness / Yoga - Other \_\_\_\_\_

**Program Start Date:** \_\_\_\_\_ **Class Day(s)/Time** \_\_\_\_\_

List any medical condition(s) that may limit/affect participation in program (please explain)

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**Prescription Medications currently taken/frequency** \_\_\_\_\_

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**Do you wear:** glasses \_\_\_\_\_ and/or contact lenses \_\_\_\_\_

**TURN OVER AND COMPLETE BACK OF FORM ALSO! --->**

**MEDICAL RELEASE FOR TREATMENT**

**I authorize the designated program instructors/staff of Intramural and Recreational Activities to authorize on my behalf all appropriate medical treatment which may be required in the event of an illness or injury to**

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Name of Participant Date of Birth

**resulting in any manner from participating in this University sponsored activity. This authority is intended to cover any illness or injury sustained while participating in any activity associated with this program.**

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Date Participant's Signature

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Date Parent/Guardian Signature if Student is under 18

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**I, \_\_\_\_\_, understand that participation in this program is on a voluntary basis, and acknowledge that neither the University nor the Department of Intramural & Recreational Activities will accept responsibility for injuries sustained while participating in these activities. All participants are strongly encouraged to carry their own insurance for any unforeseen accident(s). I, the participant (parent or guardian if a minor), have read and understand this statement and agree to notify the Department of Intramural & Recreational Activities if there is any change in my health status during my participation in this program. Any information I have provided on this form is true, correct and complete to the best of my knowledge.**

**RELEASE OF LIABILITY**

**I understand that parts of Intramural-Recreational activities may be physically demanding. I recognize the inherent risk of injury in Intramural-Recreational activities. I understand that each participant must assume the risk of injury and any related financial responsibility that could result from participation in any Intramural-Recreational activity. I agree to hold harmless Southwestern University, its employees, staff, and volunteers from all claims, including bodily injury, that I may have on my behalf that may be sustained in connection with my participation in the above mentioned activities.**

**Signature \_\_\_\_\_ Date \_\_\_\_\_**

**Parent/Guardian Signature if under 18 \_\_\_\_\_ Date \_\_\_\_\_**

**Physical Activity Readiness Questionnaire (PAR-Q)**  
**(The PAR-Q is for People Aged 18-69)**

Regular physical activity is fun and healthy and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before participating in a group fitness class.

If you wish to join a fitness class sponsored by Southwestern Intramural & Recreational Activities (SIRA), start by answering the seven questions in the box below. If you are between 18 and 69, the PAR-Q will tell you if you need to check with your doctor before starting to participate in a fitness class. **If you are 70 years of age or older, you will need to receive clearance from your physician to participate in SIRA fitness classes –see form on next page (4 of 4) of document (Physician’s Clearance Form).**

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

Yes    No

- 1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
- 2. Do you feel pain in your chest when you do physical activity?
- 3. In the past month, have you had chest pain when you were not doing physical activity?
- 4. Do you lose your balance because of dizziness or do you ever lose consciousness?
- 5. Do you have a bone or joint problem (e.g. back, knee, or hip) that could be made worse by a change in your physical activity?
- 6. Is your doctor currently prescribing drugs (e.g. water pills) for your blood pressure or heart condition?
- 7. Do you know of any other reason why you should not do physical activity?

**If you answered YES to one or more questions:**

Talk with your doctor by phone or in person in order to be cleared for participation in SIRA fitness classes. Tell your doctor about the PAR-Q and about the questions to which you answered YES.

- Share the form on the reverse side of this sheet with your doctor in order to obtain his/her clearance to participate in one or more SIRA fitness class(es).
- Talk with your doctor about the activities/classes that you wish to do and follow his/her advice.

**If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:**

- Start becoming more physically active – begin slowly/build gradually to be safe.
- Take part in a fitness appraisal – this is an excellent way to determine you basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.
- Note: If your health changes so that you then answer YES to any of the above questions, please consult with your doctor for a physical evaluation and request another PAR-Q form from SIRA.

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

Signature \_\_\_\_\_ Today’s Date \_\_\_\_\_

## **Physician's Clearance Form**

On the Physical Activity Readiness Questionnaire you just completed, you either indicated that you were at least 70 years old or you identified that you have one or more medical risk factors, which may impair your ability to exercise safely. Therefore, you must have a physician complete and return this medical clearance form before you can begin/continue exercising in group fitness classes sponsored by Southwestern Intramural & Recreational Activities (SIRA).

We recognize that you are eager to participate in a fitness program, and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your exercise experience with SIRA to be as safe as possible. For this reason, we have implemented this policy of requiring physician's clearance that follows the current standards of the American College of Sports Medicine.

In order to expedite this process, we will gladly fax this form directly to the physician of your choice. If the doctor is aware of your medical history, he/she may be able to complete this form and fax it right back to us.

### **To Be Completed By Program Participant**

I hereby give my physician permission to release any pertinent medical information from any medical records to SIRA/ Southwestern University. All information will be kept confidential.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Information requested for \_\_\_\_\_

Reason for requesting medical clearance \_\_\_\_\_

Physician's name \_\_\_\_\_ Phone # \_\_\_\_\_

Fax # \_\_\_\_\_ Address \_\_\_\_\_

### **For Physician Use Only**

Please check one of the following statements:

- I concur with my patient's participation with no restrictions.
- I concur with my patient's participation in an exercise program if he/she restricts activities to:  
\_\_\_\_\_
- I do not concur with my patient's participation in an exercise program

Reason: \_\_\_\_\_

Physician's name \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

**Please return completed form to Derek Timourian, SIRA Director, Fax(512)863-1393.  
Feel free to call 863-1665 with questions or for more information.**