



Personal Training • Sport Performance • Specialty Private Training

New Client Packet

Personal Training Options

- Personal Training - general health, fitness, strength, and endurance training with a nationally-certified personal trainer.
- Sport Performance – athletic-based and sport-specific training with personal trainers specializing in strength & conditioning or sport performance.
- Pilates Reformer or Yoga Private Training –individualized sessions with a Pilates reformer or yoga specialty fitness instructor.
- Chronic Conditions Private Training –individualized training with nationally-certified personal trainers specializing in exercise protocols for early stages of multiple sclerosis, Parkinson's disease, dementia, cancer at any stage, and other chronic conditions utilizing neuroplasticity, balance, cardio, strength, and flexibility training.

Our goal is to customize a fitness program to fit your unique needs. Sessions include any combination of consultation, assessment and training time to ensure your program is appropriate for you and your goals.

Complete the **Health History Questionnaire, PAR-Q+, Informed Consent, Release and Indemnification, Client Agreement and Cancellation Forms** in this packet prior to your first scheduled appointment. **Physician's Consent Form** is needed if you have two or more chronic conditions or answer yes to any PAR-Q+ medical follow-up questions. **MUST** turn in or have all at your first session.

Review of forms and your health with fitness staff is a crucial part of your first session.

Information: Fitness Specialist: 303.409.2263 • Fitness Assistant: 303.409.2265

HEALTH HISTORY QUESTIONNAIRE

Physician Consent is needed prior to participation in Personal Training Services if you:

- Have two or more chronic conditions or answered yes to PAR-Q follow-up questions.
- Have any conditions prohibitive to fitness testing or exercise.

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Participant Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone (home) _____ (cell/work) _____ Date of Birth _____

E-mail _____ Height _____ Weight _____

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PAST HISTORY

Check if you've had . . .

___ heart murmur

___ high blood pressure

___ disease of arteries

___ high cholesterol

___ heart attack

___ chest pain

___ stroke

___ cancer

___ lung disease

___ epilepsy

___ diabetes mellitus

___ operations

___ varicose veins

___ injuries to back, knees, ankles

___ other

FAMILY HISTORY

Including parents,

grand parents, siblings

___ heart attacks

___ high blood pressure

___ heart operations

___ congenital heart disease

___ cancer

___ diabetes mellitus

___ other major illnesses

PRESENT SYMPTOMS

Do you experience . . .

___ chest pains

___ heart palpitations

___ cancer

___ shortness of breath

___ back pain

___ arthritis

___ swollen legs

___ injuries

___ osteoporosis

___ high blood pressure

Explain each item checked: _____

PRESENT MEDICATIONS _____

Emergency Contact: Name _____ Phone _____

Participant Signature _____

(Parent/legal guardian if under 18)







PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
1) Has your doctor ever said that you have a heart condition <input type="checkbox"/> OR high blood pressure <input type="checkbox"/> ?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
3) 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 during vigorous exercise).	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer NO if you had a problem in the past, but it does not limit your current ability to be physically active. PLEASE LIST CONDITION(S) HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your doctor ever said that you should only do medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>

-  **If you answered NO to all of the questions above, you are cleared for physical activity.**
Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.
-  Start becoming much more physically active – start slowly and build up gradually.
 -  Follow Global Physical Activity Guidelines for your age (<https://www.who.int/publications/i/item/9789240015128>).
 -  You may take part in a health and fitness appraisal.
 -  If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
 -  If you have any further questions, contact a qualified exercise professional.

PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.




NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

 **If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.**

Delay becoming more active if:

-  You are currently experiencing a temporary illness, such as a cold or fever. It is best to wait until you feel better.
-  You are pregnant. In this case, talk with your health care practitioner, physician, qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
-  Your health changes. Answer the questions on Pages 2 and 3 of this document and/or talk to your health care practitioner, physician, or qualified exercise professional before proceeding with any physical activity program.

PAR-Q+

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?

If the above condition(s) is/are present, answer questions 1a-1c

If **NO** ☐ go to question 2

- | | | |
|-----|--|--|
| 1a. | Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?
(Answer NO if you are not currently taking medications or other treatments) | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 1b. | Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 1c. | Have you had steroid injections or taken steroid tablets regularly for more than 3 months? | YES <input type="checkbox"/> NO <input type="checkbox"/> |

2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a-2b

If **NO** ☐ go to question 3

- | | | |
|-----|---|--|
| 2a. | Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 2b. | Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)? | YES <input type="checkbox"/> NO <input type="checkbox"/> |

3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm

If the above condition(s) is/are present, answer questions 3a-3d

If **NO** ☐ go to question 4

- | | | |
|-----|---|--|
| 3a. | Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?
(Answer NO if you are not currently taking medications or other treatments) | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3b. | Do you have an irregular heart beat that requires medical management?
(e.g., atrial fibrillation, premature ventricular contraction) | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3c. | Do you have chronic heart failure? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3d. | Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months? | YES <input type="checkbox"/> NO <input type="checkbox"/> |

4. Do you currently have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b

If **NO** ☐ go to question 5

- | | | |
|-----|---|--|
| 4a. | Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?
(Answer NO if you are not currently taking medications or other treatments) | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 4b. | Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication?
(Answer YES if you do not know your resting blood pressure) | YES <input type="checkbox"/> NO <input type="checkbox"/> |

5. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes

If the above condition(s) is/are present, answer questions 5a-5e

If **NO** ☐ go to question 6

- | | | |
|-----|--|--|
| 5a. | Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 5b. | Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness. | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 5c. | Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, OR the sensation in your toes and feet? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 5d. | Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)? | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 5e. | Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future? | YES <input type="checkbox"/> NO <input type="checkbox"/> |

PAR-Q+

6. Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome

If the above condition(s) is/are present, answer questions 6a-6b

If **NO** ☐ go to question 7

6a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

6b. Do you have Down Syndrome **AND** back problems affecting nerves or muscles? YES ☐ NO ☐

7. Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure

If the above condition(s) is/are present, answer questions 7a-7d

If **NO** ☐ go to question 8

7a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

7b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy? YES ☐ NO ☐

7c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week? YES ☐ NO ☐

7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? YES ☐ NO ☐

8. Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia

If the above condition(s) is/are present, answer questions 8a-8c

If **NO** ☐ go to question 9

8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? YES ☐ NO ☐

8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)? YES ☐ NO ☐

9. Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event

If the above condition(s) is/are present, answer questions 9a-9c

If **NO** ☐ go to question 10

9a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

9b. Do you have any impairment in walking or mobility? YES ☐ NO ☐

9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? YES ☐ NO ☐

10. Do you have any other medical condition not listed above or do you have two or more medical conditions?

If you have other medical conditions, answer questions 10a-10c

If **NO** ☐ read the Page 4 recommendations

10a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months? YES ☐ NO ☐

10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)? YES ☐ NO ☐





10c. Do you currently live with two or more medical conditions? YES ☐ NO ☐

**PLEASE LIST YOUR MEDICAL CONDITION(S)
AND ANY RELATED MEDICATIONS HERE:**

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

PAR-Q+




 **If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:**

-  It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
-  You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
-  As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
-  If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

 **If you answered YES to one or more of the follow-up questions about your medical condition:**

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+** at **www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

 **Delay becoming more active if:**

-  You are currently experiencing a temporary illness, such as a cold or fever. It is best to wait until you feel better.
-  You are pregnant. In this case, talk to your health care practitioner, physician, qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
-  Your health changes. Talk to your health care practitioner, physician, or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____

DATE _____

SIGNATURE _____

WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact

www.eparmedx.com
Email: eparmedx@gmail.com

Citation for PAR-Q+

Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

Key References

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-S298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

Foothills Park & Recreation District

Informed Consent

In order to assess cardiovascular function, strength and flexibility before and after an exercise intervention, the undersigned hereby voluntarily consents to engage in graded exercise tests, flexibility and strength.

1. Purpose and Explanation of Exercise and Tests

All tests and exercises will be explained and specific to individual needs and the mode of training – i.e. Pilates, yoga, general fitness, sport performance, chronic conditions. The participants agrees to ask questions or stop at any time if they have questions, symptoms or safety concerns. A variety of exercises and tests (assessments) may be administered to determine the best way to proceed with training based on individual needs and goals. Tests may include resting measures, blood pressure, body composition, strength, power, speed, flexibility, balance, and cardiorespiratory tests.

Cardiorespiratory assessments may include step tests, walking or running tests or a graded exercise test performed on a motor driven treadmill with the amount of effort gradually increasing. Tests and exercises are stopped when a certain time, number of repetitions or pre-determined heart rate is reached, at any time due to symptoms such as fatigue, shortness of breath, or chest discomfort, or at the participant's request to stop. The sub-maximal graded exercise test will test the capacity and function of the cardiovascular system. Depending on the protocol used, the test is stopped when a certain time is reached, or the participant reached a pre-determined heart rate. The test may be stopped at any time because of fatigue or discomfort. The strength tests consist of doing a number of repetitions to volitional fatigue or until a specific time has been reached. These tests may be adjusted according to the needs of the individual.

2. Risks and discomforts

During exercise and testing certain changes or risks may occur including but not limited to abnormal blood pressure, fainting, disorders of heart rhythm, and very rare instance of heart attack or other bodily injury. The risks during strength testing and exercise consist of muscle strain or injury or the irritation of surgery-affected limbs, which could lead to lymphedema. A variety of other possible occurrences exist, any one of which could conceivably, however remotely, cause bodily injury, impairment, disfigurement, disability or death. Any testing or exercise carries with it some risk, however unlikely or remote. The undersigned acknowledges and agrees to assume all risk.

Foothills Park & Recreation District

Informed Consent (continued)

3. Expected benefits from testing

These tests and exercises allow fitness professionals to assess physical working capacity, strength and fitness compared to general or sport-specific populations or to appraise your physical fitness status clinically. The results are used to by program staff to evaluate exercise status or needs to prescribe a safe, sound exercise program and monitor changes. Records are kept confidential unless you consent to release this information.

4. Inquiries

Questions about the procedures used in these tests are encouraged. Individuals agree to ask for further explanation for any additional questions or needed information.

5. Freedom of consent

Performance of any exercise or testing is strictly voluntary at the discretion of the individual. Participants are free to deny consent and discontinue training exercises or testing any time desired. I have read this form carefully and I fully understand the test procedures. I consent to participate in this test.

I have read this Foothills Park & Recreation District Informed Consent form carefully, fully understand its terms, and consent to participate in testing and training exercises for fitness, sport performance, chronic conditions, yoga, Pilates or other private fitness training.

Participant Name (printed – include parent/legal guardian if under 18)

Participant Signature (parent/legal guardian if under 18)

Date

Witness Signature

FOOTHILLS PARK & RECREATION DISTRICT

RELEASE AND INDEMNIFICATION FORM

We strongly recommend that all participants consult their physician prior to participation.

In consideration of the acceptance of my participation in the Foothills Park & Recreation Districts Personal Training Program, I, the undersigned, intending to be legally bound for myself, my heirs, executors, administrators, and assignees, do hereby waive, release, and forever discharge Foothills Park & Recreation District ("District"), its agents, contractors, employees, representatives, successors, and assignees, from all liabilities, actions, claims, demand, damages, costs, and expenses, which I may now or in the future have against them or any of them arising out of or in any way connected with my participation in the program, including but not limited to all injuries that may be suffered by me. I understand that this waiver includes, but is not limited to any claims that are based on negligence or other action or inaction of the above named parties. In further consideration of the acceptance of my entry, the undersigned indemnifies and holds harmless Foothills Park & Recreation District, its officers, directors, agents, and employees against all liabilities, claims, damages, and expenses of every kind and nature which grow out of or are in any way connected with the conduct or organization of this program.

1. I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment, are potentially hazardous activities. I also understand that fitness activities involve a risk of injury and even death, and I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I agree to expressly assume and accept any and all risks of injury or death.

2. I do further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or other illness that would prevent my participation or use of equipment and machinery. I do acknowledge that I have been informed of the desirability for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to my physical activity, exercise, and use of exercise and training equipment so I might have his/her recommendations concerning these fitness activities and equipment use. I affirm that I have either had a physical examination and have been given my physician's permission to participate, or that I have decided to participate in activity and use of equipment and machinery without the approval of my physician; and I assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

Participant Name (printed – include parent/legal guardian if under 18)

Participant Signature (parent/legal guardian if under 18)

Date

Foothills Park & Recreation District

Client Agreement & Cancellation Policy

I understand and agree to the following:

- Willingly inform my personal trainer or instructor of health changes, precautions or limitations and submit updated Health History and PAR-Q+ forms.
- Notify my personal trainer of any medication changes.
- Give at least 24-hour notice for cancellation of appointments (emergencies will be taken into consideration); otherwise, I agree to make a full payment for the session.
- Arrive on time. If I don't show up within 10 minutes of my scheduled start time, it is considered a "no show" and I will be charged full payment. Session will end on time even if I'm late.
- Sessions will consist of any combination of consultation, assessments, exercises, testing and training.
- Personal training may require physical contact for safety &/or spotting of some exercises/stretchers and in developing body awareness and/or correcting body position or alignment. Personal trainer will inform you as needed.
- Stop participation and communicate any concerns, symptoms (i.e. joint pain, dizziness, etc.) or if something doesn't feel safe.

Participant Name _____

(Parent/Legal Guardian if under 18 years)

Client Signature (parent/legal guardian if under 18) **Date**

Personal Trainer or Fitness Staff Signature **Date**