



UNIVERSITY OF NEBRASKA AT OMAHA

Personal Training Information & Policies

EXPIRATION DATE OF TRAINING SESSIONS

Personal training sessions will expire 6 months from the date of purchase unless serious extenuating circumstances prevent the client from returning. Extending the expiration date is allowed upon agreement between the client, the personal trainer, and UNO Campus Recreation management.

LATE POLICY

Clients must be dressed appropriately and ready to participate at the time of the scheduled session. The trainer is only required to wait for the client for 10 minutes. If a session begins late due to the client, the trainer has the right to deduct those minutes off of the session. The trainer is also responsible for arriving and being prepared to begin on time. Sessions will start and end on time.

CANCELLATION POLICY

If a client must miss a scheduled personal training appointment due to illness, emergency, travel or etc., they should notify the personal trainer at the earliest possible date and make arrangements with the trainer to reschedule the appointment. If a client does not notify the personal trainer within 24 hours, they will be charged for that session as if they had used it. The trainer is also responsible for giving a client 24 hours notice if he/she needs to cancel an appointment.

REFUND POLICY

If a client is restricted from physical activity by his/her physician, he/she may suspend his/her training membership with written verification from his/her physician. A refund of any un-used training sessions will be granted.

INITIAL

UNIVERSITY OF NEBRASKA AT OMAHA

Personal Training Information & Policies

INFORMED CONSENT

Informed consent for participation in a health and fitness training program.

NAME _____

DATE OF BIRTH _____ CELL PHONE _____ WORK PHONE _____

ADDRESS _____

EMAIL ADDRESS _____

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 which are recommended to me for improvement of dietary counseling, stress management, and health/fitness education activities. The levels of exercise I perform will be based upon my cardiorespiratory (heart and lungs) and muscular fitness. I understand that I may be required to undergo a graded exercise test 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. A professionally trained personal fitness trainer will provide leadership to direct my activities, monitor my performance, 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, stress management, and other health and fitness regarded programs. If I am taking prescribed medications, I have already so informed the program staff and further agree to so inform them promptly of any changes which my doctor or I have made with regard to use of these. I will be given the opportunity for periodic assessment and evaluation at regular intervals after the start of the program.

I have been informed that during my participation in the above described 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 this 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, should any develop.

I understand that during the performance of exercise, a personal fitness trainer will periodically monitor my performance and, perhaps measuring my pulse, blood pressure, or assess my feelings of effort for the purposes of monitoring my progress. I also understand that the personal fitness trainer may reduce or stop my exercise program when any of these findings so indicate that this should be done for my safety and benefit.

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 to ensure that I am using proper technique and body alignment. I expressly consent to the physical contact for the stated reasons above.

UNIVERSITY OF NEBRASKA AT OMAHA

Personal Training Information & Policies

RISKS

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

BENEFITS TO BE EXPECTED AND ALTERNATIVES AVAILABLE TO EXERCISE

I understand that this program may or may not benefit my physical fitness or general health. I recognize that involvement in the personal fitness training sessions will allow me to learn proper ways to perform conditioning exercises, use 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 instructions, that I will likely improve my exercise capacity and fitness level after a period of 3-6 months.

CONFIDENTIALITY AND USE OF INFORMATION

I have been informed that the information which is 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, to the use of any information which is not personally identifiable with me for research and statistical purposes so long as same does not identify my person or provide facts which could lead to my identification. Any other information obtained, however, will be used only by the program staff to evaluate my exercise status or needs.

INQUIRIES AND FREEDOM OF CONSENT

I have been given an opportunity to ask questions as to the procedures. I have read this Informed Consent form, fully understand its terms, understand that I have given up substantial rights by signing it, and sign it freely and voluntarily, without inducement.

PARTICIPANT'S SIGNATURE _____ **DATE** _____

PARTICIPANT'S NAME (PRINTED) _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

NAME _____ **RELATIONSHIP** _____

PERSONAL PHYSICIAN NAME _____

PHONE _____ **FAX** _____

UNIVERSITY OF NEBRASKA AT OMAHA

Personal Training Information & Policies

PRESENT/PAST HISTORY

- Rheumatic fever
- Recent operation
- Edema (swelling of ankles)
- High blood pressure
- Low blood pressure
- Injury to back or knees
- Seizures
- Lung disease
- Heart attack or known heart disease
- Fainting or dizziness
- Diabetes
- High Cholesterol
- Orthopnea (the need to sit up to breathe comfortably) or paroxysmal (sudden, unexpected attack) or nocturnal dyspnea (shortness of breath at night)
- Shortness of breath at rest or with mild exertion
- Chest pains
- Palpitations or tachycardia (unusually strong or rapid beat)
- Intermittent claudication (calf cramping)
- Pain, discomfort in the chest, neck, jaw, arms, or other areas
- Known heart murmur
- Unusual fatigue or shortness of breath with usual activities
- Temporary loss of visual acuity or speech, or short-term numbness or weakness in one side, arm, or leg of your body
- Cancer
- Other (please describe):

FAMILY HISTORY

Have any of your first-degree relatives (parent, sibling, or child) experienced the following conditions? (Check if yes.) In addition, please identify at what age the condition occurred.

- Heart attack
- Heart operation (Bypass surgery, Angioplasty, Coronary Stent placement)
- Congenital heart disease
- High blood pressure
- High cholesterol
- Diabetes
- Other major illness

Explained checked items:

UNIVERSITY OF NEBRASKA AT OMAHA

Personal Training Information & Policies

ACTIVITY HISTORY

How were you referred to this program? _____

Why are you enrolling in this program? _____

Yes____ No____ Have you ever worked with a personal trainer before?

Date of your last physical examination performed by a physician _____

Yes____ No____ Do you participate in a regular exercise program at this time?

If yes, briefly describe _____

Yes____ No____ Can you currently walk four (4) miles briskly without fatigue?

Yes____ No____ Have you ever performed resistance training exercises in the past?

Yes____ No____ Do you have injuries (bone or muscle disabilities) that may interfere with exercising?

If yes, briefly describe _____

Yes____ No____ Do you smoke? Amount per day _____ Age started _____

What is your body weight now? _____ What was it one year ago? _____ At age 21? _____

How tall are you? _____

Yes____ No____ Do you follow or have you recently followed any specific dietary intake plan?

In general, how do you feel about your nutritional habits?

List the medications you are presently taking.

List in order your personal health and fitness objectives.

UNIVERSITY OF NEBRASKA AT OMAHA

Physician Release Form

At the University of Nebraska at Omaha, your safety is our primary concern. For that reason, we comply with the health and fitness standards of the American College of Sports Medicine.

On the AHA/ACSM Health/Fitness Facility Participation Screening Questionnaire, you identified that you have one or more health history concerns, symptoms, or cardiovascular risk factors which may impair your ability to exercise or participate in Group Exercise classes safely. For your safety, your physician must complete this medical clearance form. Before you can participate in Group Exercise classes at the University of Nebraska at Omaha, you must return this form.

We recognize that you are eager to participate, and we sincerely regret any inconvenience this may cause you. However, please keep in mind that we want your exercise experience to be as safe as possible.

In order to expedite this process, we will gladly fax this form directly to the physician of your choice when you provide his/her name and fax number.

FOR PHYSICIAN USE ONLY

Attention Dr. _____ Fax Number _____

Release for _____ to participate in fitness classes.

Please review the items checked on the Health Information and check one of the following statements:

I concur with my patient's participation in fitness classes with no restrictions.

I concur with my patient's participation in fitness classes with the following restrictions:

I do not concur with my patient's participation in fitness classes.

(If checked, the individual will not be allowed to participate in fitness classes.)

Physician's Name *(type or print)* _____

Physician's signature _____

Date ____/____/____