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LENEXA REC CENTER

17201 W. 87TH ST. PKWY.
LENEXA, KS 66219

PERSONAL TRAINING PROGRAM APPLICATION

PARTICIPANT INFORMATION

Name: Date of Birth:

Address:

City: State: ZIP:

Phone: ☐ Home ☐ Cell ☐ Work

Email:

EMERGENCY CONTACT

Name:

Phone: ☐ Home ☐ Cell ☐ Work

Relationship to Participant:

All participants are advised to speak with a doctor prior to participating in the personal training program ("Program").

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE

1. Has a doctor ever said that you (or the participant, if a minor) have a heart condition **and** that you (or the participant) should only do physical activity recommended by a doctor? ☐ Yes ☐ No
2. Do you (or the participant) feel pain in your chest during physical activity? ☐ Yes ☐ No
3. In the past month, have you (or the participant) had chest pain when not doing physical activity? ☐ Yes ☐ No
4. Do you (or the participant) lose your balance because of dizziness or ever lose consciousness? ☐ Yes ☐ No
5. Do you (or the participant) have a bone or joint problem (for example, back knee or hip) that could be made worse by a change in physical activity? ☐ Yes ☐ No
6. Is your (or the participant's) doctor currently prescribing drugs (for example, water pills) for blood pressure or heart condition? ☐ Yes ☐ No
7. Do you know of **any other reason** why you (or the participant) should not do physical activity? ☐ Yes ☐ No
   If yes, explain:

If you answered "Yes" to one or more of the questions above, you are advised to talk with your doctor ***before*** you (or the participant, if a minor) start participating in the Program ***and*** you must submit the Personal Training Medical Clearance Form prior to starting the Program. Failure to submit the completed form will delay the start of your personal training program.

If you answered "No" to all of the questions above, if at any time your answer to one or more of the questions above changes to "Yes", you are advised to talk with your doctor ***before*** you continue participating in the Program and you must submit the Personal Training Medical Clearance Form prior to starting the Program.

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PERSONAL TRAINING PROGRAM APPLICATION

I certify that all of the information I have provided on this form is true, complete, and correct to the best of my knowledge and belief.

SIGNATURE

Name of Participant *(print)*: ______________________________

Name of Parent/Guardian of a Minor *(print)*: ______________________________

Signature: ______________________________

Date: ______________________________

REV 6/12/2017

FOR INTERNAL USE ONLY Entered By: ______________________________ Date: ____________________