Fitness Training Services Application

Thank you for your interest in one of our fitness training services with Boston College Campus Recreation. We are committed to helping Boston College students, faculty, staff and affiliates reach their fitness goals through a variety of services and programs. For a description of these services, please see our website, www.bc.edu/rec.

All members interested in signing up for a service must read and complete the Fitness Training Services Application, which includes the application, policies, and health history questionnaire. Please fill out the forms with as much detail as possible.

The forms must be hand delivered in a sealed envelope with a signature across the seal to Member Services. In an effort to protect your privacy and medical information, we will not accept e-mailed, mailed or faxed forms. Upon review of the forms you turn in it may be required for you to provide a medical waiver. You will be notified by the Graduate Assistant of Personal Training if the medical waiver is necessary. Payment is required prior to receiving the service.

Only members of the Flynn Recreation Complex are eligible to sign up for a fitness training service. Please keep in mind, we cannot guarantee placement with a specific personal trainer due to demand. If signing up for personal training, the client is assigned based on preferences, goals and trainer availability.

If you have any additional questions, please contact us. Congratulations and good luck as you work toward your personal health and fitness goals!

Yours in Health,

The Fitness Staff
fitness.center@bc.edu
Fitness Training Services Application

Please check the fitness training service you are applying for:

☐ Health and Fitness Assessment: Resting measurements to assess health, including body composition, and physical tests to gauge submaximal cardiovascular fitness, muscular strength and endurance, neuromuscular balance, and flexibility.

☐ InBody Assessment: Resting measurements to assess body composition.

☐ Personal Training: Personal training sessions based on the individual’s workout history, goals, and physical limitations.

□ Individual (1:1)    □ Partner (2:1)    □ Group (3-6:1)

All new personal training clients will receive a 30-minute fitness consultation prior to purchasing sessions, which will go over different package options.

Name: ___________________________________________ Date: __________________________

Status (student/faculty/staff/affiliate): ________________________________________________

Email Address: ________________________________ Phone Number: ______________________

Emergency Contact Name: ___________________________________________________________

Emergency Contact Relationship: __________________________ Phone Number: ______________

1. How often do you currently exercise?

2. What types of exercise do you prefer?

3. What fitness goals would you like to work on achieving?

4. Is there a personal trainer you would prefer working with? If yes, please write their name.
Fitness Training Services Policies

**Payment**
Payment for services is due to Member Services after the initial 30-minute fitness consultation, unless the member is a current personal training client, in which case sessions can be purchased as needed without a consultation. Returning members must pay for session(s) in advance of the session(s).

**Scheduling**
An email will be sent typically within three business days to schedule the 30-minute fitness consultation. At the consultation scheduling will be discussed in depth. The first session will be scheduled after the consultation. Please do not contact Member Services in regards to any scheduling.

**Cancellation/Rescheduling Policy**
Individual Cancellation Policy: if you need to cancel or reschedule a session, please call your trainer. If you are unable to reach your trainer directly please leave a message and email them. Cancellations and rescheduling require 24 hours notice. Failure to cancel within this time frame or failure to show up for a session will result in the client being charged for the session. Exceptions will only be made in the case of a medical emergency accompanied by a doctor’s note.

Partner Cancellation Policy: if one client cancels a partner training session within 24 hours of a session, or simply does not show, a 30-minute session will be provided to the other client if in attendance and the client who cancelled will lose a session. If one client cancels a partner training session with more than 24 hours notice, the session can be rescheduled for a 30-minute individual session if the other partner decides to keep the appointment, but it is recommended that both partners reschedule the session to get the full 60 minutes.

Group Cancellation Policy: if one client cancels a group training session, or simply does not show, the session may continue with the remaining clients. The session will still count toward the package balance for each of the clients. It is recommended that the whole group reschedules 24 hours prior to the cancellation cut-off whenever possible. Individual make-ups are not possible with these sessions.

**Tardiness Policy**
Clients are expected to begin their session at the start time of the scheduled appointment. A late start time does not entitle a client to a session longer than the scheduled appointment. Trainers will wait only 15 minutes for clients to show for a scheduled session. After 15 minutes, the session will be lost and the client will be charged for the session.

If the trainer is tardy the client has the right to either ask the trainer if he/she can complete the full session as planned, or to reschedule the session.

*A more thorough list of policies will be reviewed at the 30-minute fitness consultation.*

**I verify that I understand and will abide by these policies.**

**Client Signature** _________________________________ **Date** _____________________
Health History Questionnaire

Name (Please Print) _______________________________________________________

Date of Birth ____/____/____  Height __________  Weight ________________  Gender  M  F

Section 1

If you marked any of these statements in this section, consult your physician or other appropriate health care provider before engaging in exercise. You may need to use a facility with a medically qualified staff. The Graduate Assistant of Personal Training will notify you if we require a medical waiver from your health care provider prior to participation.

Check if you have a history of the following:

_____ Heart attack
_____ Heart surgery
_____ Cardiac catheterization
_____ Coronary angioplasty (PTCA)
_____ Pacemaker / implantable cardiac defibrillator / rhythm disturbance
_____ Heart valve disease
_____ Heart failure
_____ Heart transplantation
_____ Congenital heart disease

Check if you experience the following symptoms:

_____ You experience chest discomfort with exertion
_____ You experience unreasonable breathlessness
_____ You experience dizziness, fainting or blackouts
_____ You take heart medications

Check if you have any of the following health issues?

_____ You have diabetes
_____ You have asthma or other lung disease
_____ You have burning or cramping sensation in your lower legs when walking short distances
_____ You have musculoskeletal problems that limit your physical activity
_____ You have concerns about the safety of exercise
_____ You are pregnant
Section 2
If you marked two or more of the statements in this section, consult your physician or other appropriate health care provider before engaging in exercise. You may need to use a facility with a professionally qualified exercise staff. The Graduate Assistant of Personal Training will notify you if we require a medical waiver from your health care provider prior to participation.

**Cardiovascular Risk Factors**

- You are a male older than 45 years
- You are a woman older than 55 years or you have had a hysterectomy or you are postmenopausal
- You smoke, or quit smoking within the previous 6 months
- Your blood pressure is greater than 140/90 mm Hg
- You do not know your blood pressure
- You take blood pressure medication
- Your blood cholesterol is greater than 200 mg/dL or HDL < 35 mg/dL
- You do not know your blood cholesterol level
- You have a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister)
- You are physically inactive (you get less than 30 minutes of physical activity on at least 3 days/week)
- You are greater than 20 pounds overweight

**List all medications you take on a regular basis:**

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<th>Medication</th>
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**Please sign below if in agreement:** I have read and understood the questions asked. I verify that all the information noted above is accurate to the best of my knowledge.

Client Signature ___________________________  Date ____________________