Fit Club Application Packet

Thank you for your interest in small group training with personal training services at Boston College’s Flynn Recreation Complex. Our personal training program meets the needs of all types of clients, regardless of experience or skill level.

Before the first session of small group training can begin, all participants must complete the Small Group Training Application Packet, which includes the application, policies, and health history questionnaire. Please fill out the forms with as much detail as possible. We will only ask you to fill this packet out once per academic year, however, we request that you update the Assistant Director of Fitness and Wellness, Hilary De Vries, if your health information changes. Your health and safety is our number one concern.

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.

Please understand that while our fitness staff will work hard to meet the needs of a variety of fitness levels, not all classes are appropriate for each individual. In the case that you register for a class, but the trainer finds that the class could be harmful or not beneficial to you, then the trainer may recommend a different class, or personal training. Our trainers are not physical therapists and this is not a medically-supervised fitness facility. Please refer to the small group class descriptions on the website for information in regards to each class and contact us with any questions.

Our staff is committed to helping Boston College students, faculty, staff and affiliates reach their fitness goals through a variety of services and programs. Please visit our website for more information:

www.bc.edu/rec

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

E-mail: fitness.center@bc.edu
Fit Club Application

Name: ______________________________________________ Date: ________________

Eagle ID #: ________________

Status (check one): □ Student □ Faculty/Staff □ Alumni □ Other

Email Address: __________________________ Phone Number: _________________________

Preferred Method of Communication: □ Phone □ Email □ Other

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?

__________________________________________________________________________

__________________________________________________________________________
Small Group Training Policies

**Scheduling/Rescheduling Policy/ Cancellation**
Scheduling: Once the participant has registered through Member Services to participate in small group training he/she is committed to those sessions. The participant then needs to read and complete this packet, and then return it to Member Services.

Rescheduling: Please understand that if a client misses a small group training session and would like to participate in another class for that week, we are not able to accommodate that request. We can only guarantee you a spot in the class that you are registered. Member Services should not be contacted in regards to scheduling make-ups.

Cancellations: If a client would like to be refunded for small group training prior to the start of the program then he/she must contact Member Services. Refunds are not guaranteed after the start of the program.

**Trainer Cancellation**
The trainer will contact participants via email if he/she is unable to make the scheduled class. A make-up small group session will then be offered to each participant.

**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.

**Session Payment**
Payments for all session(s) need to be made in advance of the session(s). Payments must be received by Member Services before the start of small group training.

**Assessments**
Depending on the small group training program, there may or may not be assessments at the beginning and end of the sessions. The trainer will communicate any assessments that will occur prior to the start of the first session.

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
Please check all medical problems you have experienced within one year (unless indicated otherwise). 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.

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 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

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
Section 2

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 take blood pressure medication
- Your blood cholesterol is greater than 200 mg/dL or HDL < 35 mg/dL
- 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

Please list all medications you take on a regular basis:

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<th>Medication</th>
<th>Reason</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 _____________________

Emergency Contact Name: __________________________

Emergency Contact Relationship: ___________ Phone Number: ___________________

All applicants are required to receive medical clearance from their health care provider on the last page of this packet.
Physician’s Release

Dear Doctor:

Your patient ______________________________ is participating in Boston College Campus Recreation’s Fit Club training program. Your signature as his or her healthcare provider indicates that your patient is medically cleared to participate in fitness training provided by Boston College Campus Recreation. Without your consent your patient will not be able to participate. Boston College Campus Recreation is not a medically supervised facility and does not provide rehabilitative services as they are beyond our scope of practice.

Report of a Physician

☐ I know of no reason why the applicant may not participate

☐ I believe the client can participate, but I urge caution because:

________________________________________________________________________________________

________________________________________________________________________________________

☐ The client should not engage in the following activities:

________________________________________________________________________________________

________________________________________________________________________________________

☐ I recommend that the client NOT participate

Please include any other recommendations or restrictions on a separate page.

_________________________________________   ______________________________
Health Care Provider’s Signature                  Date

_________________________________________   ______________________________
Health Care Provider (MD, DO, PA-C, or NP)                 Office Phone

To protect your privacy: Please do not fax, mail or email this form. This form must be hand delivered to Member Services in a sealed envelope with your signature across the seal.