Employee Fitness Center Guest Form

Name: ____________________________________________

Last Name  First Name  Middle Initial

KSU# (KSU ID card): ____________________________

*Non-KSU Employees, # will be Driver’s License

Phone: _________________________________________

Email: __________________________________________

Sex:  F  M

Age Group:  16-29  30-39  40-49  50-59  60-69  70+

Name of EFC Member or Promotion: __________________________

Relationship to Member: __________________________

Emergency Information:

Contact Person: __________________________  Relationship: __________________________

Best phone # to call during day: __________________________  Night: __________________________

Medical Conditions we should be aware of (If none, write N/A):

________________________________________________________________________

________________________________________________________________________

Staff Use Only:

Date:  Guest Initials:  STAFF Initials:

1.  ________________  ________________  ______________________

2.  ________________  ________________  ______________________

3.  ________________  ________________  ______________________

4.  ________________  ________________  ______________________

5.  ________________  ________________  ______________________
# 2018 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.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1)</strong></td>
<td>Has your doctor ever said that you have a heart condition □ OR high blood pressure □?</td>
<td>□</td>
</tr>
<tr>
<td><strong>2)</strong></td>
<td>Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?</td>
<td>□</td>
</tr>
<tr>
<td><strong>3)</strong></td>
<td>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).</td>
<td>□</td>
</tr>
<tr>
<td><strong>4)</strong></td>
<td>Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE:</td>
<td>□</td>
</tr>
<tr>
<td><strong>5)</strong></td>
<td>Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:</td>
<td>□</td>
</tr>
<tr>
<td><strong>6)</strong></td>
<td>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:</td>
<td>□</td>
</tr>
<tr>
<td><strong>7)</strong></td>
<td>Has your doctor ever said that you should only do medically supervised physical activity?</td>
<td>□</td>
</tr>
</tbody>
</table>

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 International Physical Activity Guidelines for your age (www.who.int/dietphysicalactivity/en/).
- 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 centre 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** ___________________________

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

### Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmex.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 doctor or a qualified exercise professional before continuing with any physical activity program.
2018 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
   (Answer NO if you are not currently taking medications or other treatments)
   1a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?
       YES □ NO □
   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 □ NO □
   1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months?
       YES □ NO □

2. Do you currently have Cancer of any kind?
   If the above condition(s) is/are present, answer questions 2a-2b
   (Answer NO if you are not currently taking medications or other treatments)
   2a. Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?
       YES □ NO □
   2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?
       YES □ NO □

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
   3a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?
       YES □ NO □
   3b. Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)
       YES □ NO □
   3c. Do you have chronic heart failure?
       YES □ NO □
   3d. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?
       YES □ NO □

4. Do you have High Blood Pressure?
   If the above condition(s) is/are present, answer questions 4a-4b
   (Answer YES if you do not know your resting blood pressure)
   4a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies?
       YES □ NO □
   4b. Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication?
       YES □ NO □

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
   5a. Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?
       YES □ NO □
   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 □ NO □
   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 □ NO □
   5d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?
       YES □ NO □
   5e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?
       YES □ NO □
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

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)

6b. Do you have Down Syndrome AND back problems affecting nerves or muscles?

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

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)

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?

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?

7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?

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

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)

8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?

8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?

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

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)

9b. Do you have any impairment in walking or mobility?

9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?

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

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?

10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?

10c. Do you currently live with two or more medical conditions?

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.
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 have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes - talk to your doctor 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

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.

Key References


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01-11-2017
Kennesaw State University
Employee Fitness Center Policies

It is the responsibility of the KSU Employee Fitness Center to maintain a safe, clean, and friendly environment. All members will be treated in the same professional manner.

All members of the Employee Fitness Center must follow the policies and procedures of Kennesaw State University. This is to ensure that everyone will have a safe and enjoyable experience while visiting the Employee Fitness Center.

OUR OBLIGATIONS TO EFC MEMBERS INCLUDE:

- Providing a well-trained and knowledgeable staff to assist our members.
- Ensuring all building and program rules and regulations are followed for the safety and enjoyment of all members.
- Making sure the equipment is safe and in an operational condition.
- Enforcing proper attire is worn at all times for everyone’s health and safety.
  - Closed toed shoes and shirt worn at all times.
- Listening to our members to develop the best possible customer service practices possible.

ALL MEMBERS MUST COMPLY WITH THE FOLLOWING GENERAL POLICIES:

- Members are expected to be good patrons, respect the rights of others, and respect the equipment at all times.
- Provide a valid ID for access to the Employee Fitness Center.
- Abide by all policies and procedures of Kennesaw State University.
- Log in and log out on the computer.
  - Sign in/out at front desk for visitors and newer members being processed.
- Abide by program rules for the safety and enjoyment of all members.
- The Employee Fitness Center is an alcohol, drug, and tobacco free environment.
- Firearms and weapons are prohibited.
- An adult must accompany children aged 16-17 years.
  - Children under the age of 16 are not permitted in the facility.
- Animals are not permitted in the Employee Fitness Center except approved service animals.
- Beverages are permitted if carried in a closed container.
  - No glass is allowed.
- Shirts and closed toe athletic shoes must be worn at all times. Anyone dressed inappropriately will be asked to correct the deficiency or to leave the premises.
- Personal belongings must be stored in the lockers provided. The Employee Fitness Center/Kennesaw State University is not responsible for any lost or stolen articles.
- If a member brings a guest, prior the guest to using the Employee Fitness Center, they must complete a liability waiver and PAR-Q. Guest passes are limited to five per year.
- All equipment must be wiped down after use.
  - Cleaning supplies are available throughout the Employee Fitness Center.
- Solicitation of products or services is not permitted in the Employee Fitness Center unless approved by the Employee Wellness Coordinator & Fitness Center Manager.

OTHER RELEVANT INFORMATION:

- Assist the staff regarding maintenance and/or safety concerns by identifying and reporting potential problems noticed while using the equipment.
- If assistance is needed to avoid conflict, injuries, or other problems, please utilize the trained and knowledgeable staff.

Revised 8.1.2016
• Read any posted signs, schedules, and check your emails to keep informed of upcoming schedule changes.
• The Employee Fitness Center welcomes constructive feedback for improvement of the facility.
• All members exercise at their own risk. The Employee Fitness Center/Kennesaw State University does not accept responsibility for any injury sustained while participating.
• The Employee Fitness Center/Kennesaw State University does not accept responsibility for any damaged personal property or attire due to the use of fitness equipment and/or any small appliances (e.g. hairdryer, iron, etc.).
• Members should wear clean work out attire, including dirt/mud free shoes, and practice proper hygiene.

Penalties for violations of these standards range from warnings to revoking membership to the Employee Fitness Center.

Kennesaw State University
Employee Fitness Center
Cancellation Policy

The Employee Fitness Center encourages members to fulfill their membership commitment. The KSU Employee Fitness Center operates partially on membership fees and avoiding sporadic cancellations will allow for more precise budgeting.

To cancel an Employee Fitness Center membership, a cancellation form must be completed and returned to the Employee Fitness Center or e-mailed to efc@kennesaw.edu. The form can also be found on the Employee Fitness Center website.

If you have any questions or concerns, please contact the Fitness Center Manager at x 3244 or email dtzankov@kennesaw.edu.

As a member of the Employee Fitness Center, I have read, understand, and agree to follow the policies and procedures described above.

Printed Name

Department

Signature  Date

Revised 8.1.2016
RELEASE, WAIVER OF LIABILITY AND COVENANT NOT TO SUE
(READ CAREFULLY BEFORE SIGNING)

The undersigned hereby acknowledges that participation in athletic programs and recreational activities involves inherent risks of physical injury, illness or loss of personal property and assumes all such risks. The undersigned hereby agrees that for the consideration if Kennesaw State University allowing the undersigned to participate in athletic activities and in connection therewith, making available the undersigned for his/her use while participating in such programs or activities, certain equipment, facilities, grounds, or personnel of the institution, the undersigned participant does hereby waive liability, release and forever discharge of the Institution and the Board of Regents and the University System of Georgia, its members individually, and its officers, agents and employees of and from any claims, demands, rights and causes of action of whatever kind or nature, arising out of all known and unknown, foreseen and unforeseen bodily and personal injuries, damage to property and the consequences thereof, including death, resulting from my voluntary participation in or in any way connected with such recreational programs and athletic activities.

I further covenant and agree that for the consideration stated above I will not sue the Institution, the Board of Regents of the University System of Georgia, its members individually, its officers, agents, or employees for any claim for damages arising or growing out of my voluntary participation in recreational programs or athletic activities.

I understand that the acceptance of this release, waiver of liability and covenant not to sue the Institution of the Board of Regents of the University System of Georgia or any agent or employees thereof, shall not constitute a waiver, in whole or in part, of sovereign or official immunity by said Boards, its members, officers, agents, and employees.

Further, I understand that this release, waiver and liability, and covenant not to sue shall be effective during the time period indication below while I am enrolled or employed at Kennesaw State University.

Print Name: ______________________________________________________

Signature: ___________________________ Date: ________________________