

Informed Consent for Participation in a Health and Fitness Training Program

Exercise
is Medicine

AMERICAN COLLEGE
of SPORTS MEDICINE

Name: _____ Date: _____

1. 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 measure 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.

2. 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.

3. 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.

4. 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.

5. 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 Name (printed): _____ Participant's Signature: _____

Witness's Signature: _____ Date: _____

2022 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.	YES	NO
1) Has your doctor ever said that you have a heart condition <input type="checkbox"/> OR high blood pressure <input type="checkbox"/> ?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
3) 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).	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
6) 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: _____	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your doctor ever said that you should only do medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>



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 Global Physical Activity Guidelines for your age (<https://www.who.int/publications/i/item/9789240015128>).
- ☐ 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 center may retain a copy of this form for its 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.eparmedx.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.

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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

If **NO** ☐ go to question 2

- 1a. 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) 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

If **NO** ☐ go to question 3

- 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

If **NO** ☐ go to question 4

- 3a. 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) 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 currently have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b

If **NO** ☐ go to question 5

- 4a. 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) YES ☐ NO ☐
- 4b. Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure) 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

If **NO** ☐ go to question 6

- 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 ☐

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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 If **NO** ☐ go to question 7
- 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) YES ☐ NO ☐
- 6b. Do you have Down Syndrome **AND** back problems affecting nerves or muscles? YES ☐ NO ☐
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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 If **NO** ☐ go to question 8
- 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) YES ☐ NO ☐
- 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? YES ☐ NO ☐
- 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? YES ☐ NO ☐
- 7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? YES ☐ NO ☐
-
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 If **NO** ☐ go to question 9
- 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) YES ☐ NO ☐
- 8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? YES ☐ NO ☐
- 8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)? YES ☐ NO ☐
-
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 If **NO** ☐ go to question 10
- 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) YES ☐ NO ☐
- 9b. Do you have any impairment in walking or mobility? YES ☐ NO ☐
- 9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? YES ☐ NO ☐
-
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 If **NO** ☐ read the Page 4 recommendations
- 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? YES ☐ NO ☐
- 10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)? YES ☐ NO ☐
- 10c. Do you currently live with two or more medical conditions? YES ☐ NO ☐

**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.**

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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

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Key References

1. Jamnik VL, Warburton DER, Alwaro J, McKenzie DC, Shephard RJ, Bredin SSD, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation: background and research process. *APPM* 20(3): 12-19: 2011.
2. Warburton DER, Gledhill N, Jamnik VL, Bredin SSD, McKenzie DC, Shephard RJ, Chaitworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance. *Consensus Document, APIM* 30(1):52-64:2011.
3. Gledhill NM, Gledhill N, Kozak LL, Davenport A, and Gledhill N. Physical activity readiness. *British Columbia Medical Journal* 19(7):737-738.
4. Thomas S, Reading J, and Warburton D. Review of the Physical Activity Readiness Questionnaire (PAR-Q). *Canadian Journal of Sport Sciences* 19(3):174-178:2015.

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S.M.A.R.T. GOALS WORKSHEET

Crafting S.M.A.R.T. Goals are designed to help you identify if what you want to achieve is realistic and determine a deadline. When writing S.M.A.R.T. Goals use concise language, but include relevant information. These are designed to help you succeed, so be positive when answering the questions.

INITIAL GOAL

Write the goal you have in mind

S

SPECIFIC

What do you want to accomplish? Who needs to be included? When do you want to do this? Why is this a goal?

M

MEASURABLE

How can you measure progress and know if you've successfully met your goal?

A

ACHIEVABLE

Do you have the skills required to achieve the goal? If not, can you obtain them? What is the motivation for this goal? Is the amount of effort required on par with what the goal will achieve?

R

RELEVANT

Why am I setting this goal now? Is it aligned with overall objectives?

T

TIME-BOUND

What's the deadline and is it realistic?

Review what you have written and craft a new goal statement based on what the answers to the questions above revealed.