Fitness & Wellness Services

Personal Training
Equipment Orientations

<table>
<tr><td colspan="4">Personal information: Please fill out completely.</td></tr>
<tr><td>Name:</td><td colspan="2">Date:</td><td>Age:</td></tr>
<tr><td>Email:</td><td colspan="2">Primary phone:</td><td>Alternate phone:</td></tr>
<tr><td colspan="4">Address, City, State, Zip:</td></tr>
<tr><td>Are you a (check one): ____ USA Student</td><td>____USA Faculty/Staff/</td><td>____USA Alum</td><td>____ Other</td></tr>
<tr><td colspan="4">J# or Membership #: (Your membership will be verified before services are provided)</td></tr>
<tr><td>Emergency Contact:</td><td colspan="2">Phone:</td><td>Relation:</td></tr>
</table>

Fitness Services: Check the box next to the service(s) you wish to purchase.

Service	One-on-One Training	"Buddy" Training (2 clients, 1 Trainer)
Equipment Orientation	___ $15	N/A
1 Training Session	___ $30	___ $35
4 Training Sessions	___ $90	___ $105
6 Training Sessions	___ $115	___ $140
10 Training Sessions	___ $165	___ $205
12 Training Sessions	___ $190	___ $240

Payment is due upon submission of contract.
We do not make appointments without pre-payment.

List a variety of available days & times for personal training appointments:

<table>
<tr><td>1.</td><td>2.</td><td>3.</td></tr>
<tr><td colspan="3">Name of client who referred you (if applicable):</td></tr>
<tr><td colspan="3">Preferred trainer (if known):</td></tr>
</table>

Return this contract to the front desk of the Student Recreation Center and make your online payment using this site: https://jagaspx.usouthal.edu/recpay/purchase.aspx

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Waiver: To be signed by all participants who are 19 years of age or older. If participant is under 19 years of age, participant's parent or guardian must sign this release. Participant/guardian must sign in the presence of one (1) witness.

In consideration of the University of South Alabama permitting participation in this activity, I, in full recognition and appreciation of any and all risks, hazards or dangers inherent in this activity to which participant may be exposed do hereby acknowledge that I fully understand the risks involved and that I agree to assume all of the risks and responsibilities surrounding participation in this activity. If participation includes climbing the rock wall or swimming in the USA pool, I acknowledge that there are specific risks associated with rock wall climbing and swimming. I understand that I have the opportunity to ask questions to my satisfaction regarding any and all activities and associated risks prior to signing this document.

I understand that the Campus Recreation Department and the University of South Alabama, its trustees, officers, agents, servants and employees assume and accept no liability for personal injury or loss of life or damage to personal property. Further, I do for myself, my heirs and personal representatives, hereby defend, hold harmless and indemnify, release and forever discharge the Campus Recreation Department and the University of South Alabama, its trustees, officers, agents, servants and employees from and against any and all claims, demands and actions or causes of action on account of or resulting from participation in the aforesaid activity.

I understand that participation in the above activity is voluntary and not required by the University of South Alabama or the Campus Recreation Department. I understand that participant IS NOT covered by any University liability insurance.

IN WITNESS WHEREOF, I have caused this release to be signed this _____ day of _________________, 20____.

____	_________________________________
SIGNATURE OF PARTICIPANT (if 19 or over) OR PARENT/GUARDIAN (if participant is under 19)	SIGNATURE OF WITNESS
____	___________________________________
PRINTED NAME OF PARENT/GUARDIAN (if participant is under 19)	PRINTED NAME OF WITNESS

Please initial that you have read and understand the SouthFit policies below: ______

1. Participant will stay properly fed and hydrated before, during, and after exercise and dress in appropriate clothing and footwear.
2. Participant will completely disclose any health issues in the following pages.
3. Participant will report any signs or symptoms of illness, distress, or abnormalities to the trainer immediately.
4. Emergency medical personel may be called on the participant's behalf if deemed necessary by USA employees.
5. Participant may ask personal trainers or other fitness staff about the procedures and methods used during sessions.
6. Participant may withdraw from any fitness/wellness service at any time; however, all services are non-refundable.
7. Participant has two months from the date of purchase to use all sessions. Failure to do so will result in the forfeiture of the remaining sessions.
8. Cancellations: All sessions must be canceled at least 12 hours before a scheduled appointment. Failure to do so will result in the loss of your session and participant will be charged. Participant should contact the trainer directly to cancel a session.
9. Late policy: Trainers are obligated to wait only 10 minutes for no-show participants. After 10 minutes, participant will be charged as a cancellation. Sessions that start late will end on time. If participant will be late, please have the courtesy to contact the trainer. Buddy sessions with only one participant arriving will be charged the full amount.
10. Dependents must be at least 10 years old to work with a personal trainer and are limited to dependent hours, areas, and equipment. The parent/guardian must supervise dependents age 10-15 during the sessions. Participants age 16 must have a parent/guardian in the building during sessions.
11. If at any time the participant is unhappy with his/her services or relationship with the trainer, a new trainer can be obtained. Please contact Sarah Schrenk, Fitness Coordinator.

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Pages 3 and 4 ask for your medical history to determine if you need a physician's clearance to exercise, as well as any medical conditions the personal trainers need to take into consideration when planning your workouts. Please note we are not required to comply with HIPAA's Privacy Rule.

Please indicate if you have/had any of the following

___ Chronic Asthma	___ Cardiovascular Disease	___ Type 1 Diabetes	___ Hyper/Hypo Thyroid
___ Chronic Bronchitis	___ Epilepsy/Seizures	___ Type 2 Diabetes	___ Liver Disease
___ Chronic Emphysema	___ Stroke	___ Kidney Disease	___ Currently Pregnant
___ Cancer	___ Any autoimmune disease (please specify:)		
___ Cardiovascular Surgeries	___ **None of the above**		

If you have **any** of the above, **you need a physician's clearance prior to personal training. No exceptions.** Please send the Physician Release to Exercise (last page of this packet) to your doctor, and have him/her return it to Sarah Schrenk, 461-1491 (fax) or sarahrentz@southalabama.edu.

Please indicate if you have any of the following

_______	You are a male age 45+ or a female age 55+
_______	Family history of heart disease
_______	Current cigarette smoker, or quit less than 6 months ago, or constant exposure to cigarette smoke
_______	Obesity (BMI ≥ 30 kg/m^2) Height __________ Weight _________
_______	High blood pressure, or currently taking medication to control it
_______	High cholesterol or currently taking medication to control it
_______	High blood sugar (glucose) levels, when fasting
_______	Sedentary lifestyle (getting less than 30 min of exercise per day, 3 days per week)
_______	**None of the above**

If you have **two or more** of the above, **you need a physician's clearance prior to personal training. No exceptions.** Please send the Physician Release to Exercise (last page of this packet) to your doctor, and have him/her return it to Sarah Schrenk, 461-1491 (fax) or sarahrentz@southalabama.edu.

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1. Describe any physical limitations you have due to surgeries or injuries: ___________________________________
____

2. Do you have any other medical conditions that need to be taken into consideration when exercising?

___ Arthritis	___ Fibromyalgia	___ Multiple Sclerosis	___ Osteoporosis
___ Back Problems	___ Hypoglycemia	___ Nerve Problems	___ Plantar Fasciitis
___ Bone Spurs	___ Migraine Headaches	___ Orthopedic Issues	___ Other

Explain: ____

3. Please list medications you currently take: ____

The University of South Alabama Student Recreation Center reserves the right to also request a physician's or physical therapist's release to exercise for the above conditions.

Do you do cardiovascular exercise, such as walking, cycling, aerobics classes, swimming, elliptical, or playing sports?	Yes _____ No _____	Days per week: ______ Minutes each day: ______
Do you do strengthening activities such as weight lifting, yoga, or calisthenics?	Yes _____ No _____	Days per week: ______ Minutes each day: ______
Do you stretch regularly?	Yes _____ No _____	Days per week: ______ Minutes each day: ______
Are you active on a daily basis, such as gardening, housecleaning, job-related (lifting boxes, loading trucks, etc)?	Yes _____ No _____	Days per week: ______ Minutes each day: ______
What are barriers to exercise and healthy eating?	Lack of Time _____ Lack of Energy ______ Lack of Motivation___ Family Obligations____ Lack of Childcare_____ Fear of Injury___ Other: ____	
What exercises are you willing to do?		
What exercises will you not do?		
What is your reason for hiring a personal trainer? What are your goals? (please circle)	Lose Weight____ Become stronger____ Improve health____ Stress relief_____ Improve physical appearance ____ Other:____	
How do you best learn & retain information?	Auditory (listen to instructions) _____ Visual (want photos of exercises) _____ Tactile (learn by doing) ____	

Updated 12/07/2016

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Physician's Release to Exercise

Client's name: ______________________________________ Date: ______________________

I, __________________________________ (client's name), authorize the release of the below information to the Department of Campus Recreation at the University of South Alabama.

To be filled out by physician:

Please list any limitations or recommendations that you may have for an exercise program for this client. Programs may include warm-up, cool-down, cardiovascular exercise, resistance (weight) training, stretching, balance training, or myofascial release.	
Is the client on any medication that may affect the heart rate and/or blood pressure response to exercise? If so, please name.	
Please fill out the following information if available:	
Date & result of last stress test	
Blood pressure	
Fasting total cholesterol	
Fasting blood glucose	
Physician's name	
Physician's signature	
Address	
Telephone	

Please fax to Sarah Schrenk, Fitness Coordinator, 251-461-1491 or return via email to sarahrentz@southalabama.edu