

KCKCC WELLNESS & FITNESS CONSENT & RELEASE FORM

1. PURPOSE AND EXPLANATION OF PROCEDURE

I hereby consent to participate in the KCKCC Wellness and Fitness Program activities for improvement of my general health and well-being. These may include nutrition counseling, stress reduction, exercise programs and health education activities. I have received a course syllabus and I understand what is expected of me in order to complete this course. Professionally trained personnel will be available to direct my activities, monitor my performance, and otherwise evaluate my effort. I agree to abide by the rules, regulations, and policies of the KCKCC Wellness & Fitness Center. I also understand that if I have a problem or question about any rule, regulation, or policy that I should contact a fitness professional on duty. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity or other illness that would prevent my participation or use of equipment or machinery, except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery, only if I answered "Yes" to any of the questions in the Medical Release Form. If I am taking prescribed medications, I have already informed the program staff and further agree to inform them promptly of any changes that my doctor or I have made with regard to use of these.

2. RISKS

I understand that my heart rate and blood pressure will be checked prior to participation in the program. I further understand that this screening is not intended to diagnose any medical condition and that no physician will be present. I understand that I can request a fitness test to evaluate my endurance, strength and/or flexibility. I also understand that I may experience mild discomfort during a fitness test and may stop the test at any time. It is my understanding, and I have been informed, that there exists the remote possibility during exercise and fitness testing of adverse changes including abnormal blood pressure, fainting, disorders of heart rhythm, and very rare instances of heart attack, stroke or even death. I have also been informed that emergency equipment and personnel are readily available to deal with unusual situations should these occur. I will ask questions regarding any procedure that I am confused about.

3. CONFIDENTIALITY AND USE OF INFORMATION

I have been informed that the information that is obtained in this exercise program will be treated as privileged and confidential and will consequently not be released or revealed to any person without my expressed written consent. I do, however, agree to the use of any information that is not personally identifiable with me for research and statistical purposes so long as same does not identify me or provide facts that could lead to my identification. Any other information obtained, however, will be used only by the program staff in the course of prescribing exercise for me and evaluating my progress in the program.

4. AGREEMENT AND CONSENT OF LIABILITY

In consideration of being allowed to participate in the activities and programs of the Wellness & Fitness Center and to use its facilities, equipment and machinery, in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge Kansas City Kansas Community College and its directors, officers, agents, employees, representatives, successors and assignees, administrators, executors, and all others from any and all responsibilities or liability from injury or damages from my participation in any activities or my use of equipment or machinery in the above mentioned activities. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of the Wellness & Fitness Center or the use of any equipment at Kansas City Kansas Community College.

5. INQUIRING AND FREEDOM OF CONSENT

Any questions about the KCKCC Wellness & Fitness Program are welcome. If you have doubts or questions, please ask us for further explanation. Your permission to engage in the KCKCC Wellness & Fitness Program is voluntary. You are free to deny any consent if you so desire, and choose not to participate. Please state below if you deny consent to any Wellness & Fitness activity.

The Wellness & Fitness Center director will review your statement and contact you regarding permission to participate.

I further understand that there are also other remote risks that may be associated with this program. Despite the fact that a complete accounting of all these remote risks is not entirely possible, I am satisfied with the review of these risks that was provided to me and it is still my desire to participate.

I acknowledge that I have read this document in its entirety or that it has been read to me if I have been unable to read same.

I consent to the rendition of all services and procedures as explained herein by all program personnel.

Participant's Signature

Participant's Name (Please Print)

Date

Participant's Guardian (If under 18)

Wellness & Fitness Center Witness

BIOGRAPHICAL INFORMATION

Student ID: _____ Date _____ / _____ / _____

Last Name _____ First Name _____

Address _____ City _____

State _____ Zip _____ Home Telephone (_____) _____ - _____

Business Telephone (_____) _____ Birthdate _____ / _____ / _____

Sex M F Course Name _____ Course # _____ Section # _____

Emergency Contact _____ Phone (_____) _____ - _____

Relationship of Above Contact _____

Circle Status: 1) Wellness Only (C)
2) KCKCC Employee (E)

2) KCKCC Student (S)
4) Organization _____

Risk Factors

- _____ 1. Heart attack, stroke, in your past
- _____ 2. Heart attack, stroke, in your family
- _____ 3. Diabetes, anemia, in your past
- _____ 4. Epilepsy, asthma, seizure, in your past
- _____ 5. Joint/muscular problems
- _____ 6. Dizzy spells, shortness of breath
- _____ 7. Pregnant/post partum
- _____ 8. Back problem
- _____ 9. Recent heart surgery
- _____ 10 a. Medications (List below or attach)

- _____ 10 b. Male over 45 / Female over 55
(If yes, physician's permission required)
- _____ 11. Any reason why you should not exercise?

- _____ 12. Average alcoholic beverages per day (0-9)
- _____ 13. Smoking: never (0), quit (1), 1-9 a day (2),
10 - 20 per day (3), 21-30 per day (4), 31+ (5),
1-3 cigars per day (6), 4+ daily (7),
occasional pipe (8), regular pipe (9).
- _____ 14. Stress level: rarely tense (1),
1-3 times/wk (2), twice daily (3),
usually rushed, hard driven (4),
always rushed and hard driven (5)
- _____ 15. Activity: rarely exercise (1), 1-2 /wk (2),
moderate 3-5 times/wk (3), vigorous 3-5 per
wk (4), vigorous 5-7 times, athletic (5)

Goals

- _____ 1. Lose weight or inches
- _____ 2. Gain weight or inches
- _____ 3. Firm up/tone muscles
- _____ 4. Build endurance
- _____ 5. Improve athletic performance
- _____ 6. Reduce body fat percentage
- _____ 7. Reduce cardiovascular risk
- _____ 8. Lower pulse/blood pressure
- _____ 9. Lower cholesterol level
- _____ 10. Lower blood sugar
- _____ 11. Quit smoking
- _____ 12. Maintain current fitness
- _____ 13. Leisure/social activity
- _____ 14. Reduce stress

Test scores - Staff Use Only

Heart rate _____ b.p.m. B. P _____ / _____

Weight _____ lbs Height _____

Step Pulse _____ Max VO2 _____

Body Fat Sites 1 _____ 2 _____ 3 _____

Comments _____

Physical Activity Readiness Questionnaire and Medical Release

- Yes No 1. Has your doctor ever said that you have a heart condition and recommended only medically approved physical activity?
- Yes No 2. Has any doctor ever prescribed any drugs or medicine for the treatment of a heart condition?
- Yes No 3. Do you frequently have chest pain brought on by physical activity?
- Yes No 4. Have you developed chest pain at rest in the last month?
- Yes No 5. Do you often feel faint or have dizzy spells or severe dizziness?
- Yes No 6. Has a doctor ever said your blood pressure was too high?
- Yes No 7. Do you have a bone or joint problem that has been aggravated with exercise or might worsen with exercise?
- Yes No 8. Is there a good reason not mentioned here why you should not follow an activity program even if you wanted to?. Please explain below:
- Yes No 9. Are you a female over the age of 55 or a male over the age of 45?
- Yes No 10. Are you unaccustomed to regular exercise?

STOP HERE!

If you circled **yes** to any question, please take this form to your physician for an approval to exercise.

PHYSICIAN'S PERMISSION

Please list in detail any limitations this person may have to physical activity. This includes medications that affect the exercise heart rate (60-85% of Max HR).

Patient's Name:

Physician's Signature: _____ Print Name:

Date: _____ Telephone: _____

Address: _____