



## *Winter Speed and Agility Camp*

*Presented By: Ryan Lessman, MPH, NASM-CPT*

*Name:* \_\_\_\_\_ *DOB:* \_\_\_\_\_ *Age:* \_\_\_\_\_ *Grade:* \_\_\_\_\_

*Address:* \_\_\_\_\_ *City/ State/ Zip:* \_\_\_\_\_

*Home Phone:* \_\_\_\_\_ *Cell Phone:* \_\_\_\_\_

*Parent/Guardian (print):* \_\_\_\_\_

*Parent Phone:* \_\_\_\_\_

*Session (Please circle):*

➤ *8-11(M/ F@ 4:05)*



➤ 12- 15 (Tues/Thurs @4:05)

➤ 16-18 (Wed/Fri @ 3:15)

T-Shirt Size: Youth S M L XL XXL 3XL

Adult S M L XL XXL 3XL

Return to Maryville Community Center with \$200 payment by December 16, 2016—space is limited and seats are first-come, first-serve. Check, cash, gift certificates, credit and debit cards accepted.

### PAR Q & YOU

#### The Physical Activity Readiness Questionnaire

YES NO

\_\_\_ \_\_\_ Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?

\_\_\_ \_\_\_ Do you feel pain in your chest when you do physical activity?

\_\_\_ \_\_\_ In the past month, have you had chest pain when you weren't doing physical activity?

\_\_\_ \_\_\_ Do you lose your balance because of dizziness or do you ever lose consciousness?



\_\_\_ \_\_\_ *Do you have a bone or joint problem that could be made worse by a change in physical activity?*

\_\_\_ \_\_\_ *Is your doctor currently prescribing drugs (example-water pills) for your blood pressure or heart condition?*

\_\_\_ \_\_\_ *Do you know of any other reason why you should not do physical activity?*

*Participant Name (print):* \_\_\_\_\_ *Age:* \_\_\_\_\_

*Parent/Guardian Signature :* \_\_\_\_\_

*Date:* \_\_\_\_\_

**READ CAREFULLY BEFORE SIGNING, AND INITIAL EACH PARAGRAPH AS YOU READ.**



\_\_\_\_\_I understand that there is an inherent risk of physical harm associated with participating in a fitness program and related use of exercise equipment. I understand that it is my responsibility, before participating, to inform my personal physician of my intentions, so that my physician can determine if participation is appropriate.

\_\_\_\_\_I understand that Ryan Lessman is not conducting a medical program and will not correct any pre-existing medical conditions, nor will it serve as a medical assessment or referral service for any condition that may arise while being involved in personal training.

\_\_\_\_\_I understand that while exercising, there is a possibility that any of the following may occur: changes in blood pressure, changes in heart rhythm, fainting, and in rare instances...heart attack, stroke, or even death.

\_\_\_\_\_I agree to release and hold harmless Ryan Lessman and his affiliated entities, their respective employees, agents, directors, and officers, from and against any and all liability, costs, and damages arising from my participation in personal training.

\_\_\_\_\_I certify that, to the best of my knowledge, I have not withheld any pertinent information relating to my personal health or physical conditioning.



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Parent/Guardian Signature

Date

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Ryan Lessman, NASM Certified Personal Trainer

Date

### MEDICAL HISTORY QUESTIONNAIRE

Have you ever had or been diagnosed by a physician with any of the following?

- |   |   |
|---|---|
| <input type="checkbox"/> Heart Disease                                      | <input type="checkbox"/> Angina/Chest Pain      |
| <input type="checkbox"/> Irregular Heart Beat                               | <input type="checkbox"/> High Cholesterol       |
| <input type="checkbox"/> Heart Murmur                                       | <input type="checkbox"/> Ankle Edema (Swelling) |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Dizziness              |
| <input type="checkbox"/> Heart Attack                                       | <input type="checkbox"/> Diabetes: Type I       |
| <input type="checkbox"/> Type II  |   |
| <input type="checkbox"/> Shortness of breath during exercise                |   |
| <input type="checkbox"/> Hypertension (high blood pressure during exercise) |   |
| <input type="checkbox"/> Other (please explain): _____                      |   |
- 
-



*Has anyone in your family (mother, brother, sister, grandparents) had a heart attack or other heart related problem before the age of 55?*

*[    ] Yes [    ] No*

*If yes, please explain: \_\_\_\_\_*

*Do you currently have any of the following?*

*[    ] Back pain*

*[    ] Allergies*

*[    ] Joint, tendon, or muscular pain [    ] Other: \_\_\_\_\_*

*If yes, please explain: \_\_\_\_\_*

*Please list all prescription medication(s) presently being taken:*

*Name:*

*Reason:*

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*Do you smoke or use smokeless tobacco? [    ] Yes [    ] No*

*Are you now or have you ever been on a diet? [    ] Yes [    ] No*

*If yes, please explain: \_\_\_\_\_*

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How many meals do you usually eat per day? \_\_\_\_\_

How many hours of sleep do you usually average per night? \_\_\_\_\_

Are you currently under the care of a physician? [  ] Yes [  ] No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

How much time are you willing to devote to an exercise program?

\_\_\_\_\_ minutes/day \_\_\_\_\_ days/week

Are you currently involved in a regular endurance (cardiovascular) training? [  ] Yes [  ] No

[  ] Yes [  ] No

Type(s) of exercise: \_\_\_\_\_

\_\_\_\_\_ minutes/day \_\_\_\_\_ days/week

Are you currently involved in a regular resistance (strength) training? [  ]

Yes [  ] No

Type(s) of exercise: \_\_\_\_\_

\_\_\_\_\_ minutes/day \_\_\_\_\_ days/week