City of Burnaby

SMALL GROUP TRAINING INFORMATION PACKAGE (UNDER 19)

Please complete form thoroughly.
All information received on this form will be treated as strictly confidential.

Personal Trainer: _____ **Date:** _____

Last Name: _____ First Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

☐ Home Phone: _____ ☐ Bus. Phone: _____ ☐ Cell Phone: _____
(Please check which of the above numbers is best to reach you)

Email: _____ Occupation: _____

Gender: _____ Birthday: _____ Preferred Facility: _____

Emergency Contact:

Name: _____ Number: _____ Relationship: _____

Physician Information:

Name: _____ Phone Number: _____

Fitness Related Questions

Sports or training history if any _____

How often do you currently participate in physical activity?

☐ 5-7 times/week ☐ 3-4 times/week ☐ 1-2 times/week ☐ not in the past 6 months

If active, list your activities (Cardio, Sports, Strength Training, Stretching).

Activity	Frequency/Week	Average Time	Easy/Moderate/Hard

Goal Setting

In order to increase your chances of being successful at achieving your goals, our Personal Trainers believe all your goals must be 'SMART' - Specific, Measurable, Attainable, Relevant and Time calibrated.

Check which goals you would like to accomplish:

- ☐ Reduce Fat
- ☐ Increase Strength
- ☐ Improve Sport Specific Skills
- ☐ Increase Flexibility
- ☐ Improve Cardiovascular Fitness
- ☐ Improve Bone Density
- ☐ Build Muscle Mass
- ☐ Improve Exercise Technique
- ☐ Increase Motivation
- ☐ Improve Health
- ☐ Improve Eating Habits
- ☐ Pre/Post Natal Care
- ☐ Rehabilitation
- ☐ Reduce Stress
- ☐ Add Variety to Exercise Regime
- ☐ Other: _____

Please rate on a scale from 1 to 10, how important it is for you to reach your goal(s) _____

Please describe your goals for the next 3-6 months _____

Please describe your goals for the next 6-12 months _____

How would you like to monitor your success? (i.e., body measurements, cardio, test, log book)

Do you have a support network to help you stay on track?

Help Us Help You

What are your current barriers preventing you from reaching your goals?

- ☐ Lack of interest
- ☐ Lack of time
- ☐ Lack of knowledge
- ☐ Boredom of exercise
- ☐ Motivation
- ☐ Illness or injury: Please note any injury that has occurred within the past 2 years
- ☐ Other:

How can the trainer help you stay focused? (i.e., words of encouragement, examples of measured progress)

Please describe your level of physical activity at your work place. (i.e., sitting/standing)

Lifestyle and Behavior Related Questions

Overall, how would you rate your nutrition? ☐ **Low** ☐ **Medium** ☐ **High**

1. How many meals a day do you eat? _____
2. How many glasses of water do you drink each day? _____
3. How often do you eat out each day? _____
4. How many servings of fruit do you eat each day? _____
5. How many servings of vegetables do you eat each day? _____
6. How many meals include prepackaged / processed foods do you eat each day? _____
7. How many cups of coffee do you have per day? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ more than 6
8. How many glasses of alcohol do you drink per week? ☐ 0 ☐ 1-2 ☐ 3-5 ☐ more than 6
9. Do you take vitamins or supplements? ◉ No ◉ Yes, please list: _____

Are you a smoker? ◯ No ◯ Yes, indicate how many per day _____ number of years _____

How many hours do you regularly sleep at night? _____

How would you rate the quality of your sleep? ☐ Low ☐ Medium ☐ High

How would you rate your stress levels? ☐ Low ☐ Medium ☐ High

How do you cope with stress?

_____

_____

* Your trainer is not certified to give you a meal plan, however, it is helpful for them to know what your general nutrition looks like.

2023 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 ☐ **OR** high blood pressure ☐?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
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).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** _____	☐	☐
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:** _____	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

☑ **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 chemotheraphy 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 ☐

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

www.eparmedx.com
Email: eparmedx@gmail.com

Citation for PAR-Q+
Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

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

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

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PARTICIPANT AGREEMENT

I, _____, wish to participate in The City of Burnaby Personal Training program, offered by the City of Burnaby. I understand there are some risks in participating in a program of strenuous exercise.

1. I certify that the answers to the questions outlined on the PAR-Q+ Form are true and complete to the best of my knowledge. I acknowledge that medical clearance is required if I have answered YES to any of the questions on the PAR-Q+ form.

2. I understand and agree that it is my responsibility to inform my Personal Trainer of any conditions or changes in my health, now and ongoing, which might affect my ability to exercise safely and with minimal risk of injury.

3. I understand that should I feel light headed, faint, dizzy, nauseated or experience pain/discomfort that I am to stop the activity and inform my Personal Trainer or any City of Burnaby employee or volunteer.

4. I understand that I am not obligated to perform nor participate in any activity that I do not wish to do, and that is my right to refuse such participation at any time during my Personal Training session.

5. I understand the results of any fitness program cannot be guaranteed and that my progress depends on my effort and cooperation in and out side of the Personal Training session.

6. I understand that all Personal Training sessions are 60 minutes in duration with a grace period of five minutes. Should I arrive late there is no guarantee that I will receive the full session with my trainer.

7. I understand that the City of Burnaby bills its Personal Training clients on a pre-pay basis. Payment is to be made to The City of Burnaby at any City of Burnaby Recreation facility prior to the sessions being conducted.

8. I understand that The City of Burnaby Personal Training Program works on a schedule appointment basis and thus, requires that I provide 24 hours notice when canceling an appointment. No charge will be levied should I cancel with MORE than 24 hours notice given. However, should I cancel a session with LESS than 24 hours prior notice, or fail to show for a scheduled session without any notification, then I will be charged for that session.

9. I understand that all Personal Training sessions are non-transferable and non-refundable. I also understand that all Personal Training sessions must be redeemed within 3 months of purchase.

10. I understand that my Personal Training sessions are to be completed in attendance with my trainer and do not include privileges to any City of Burnaby Recreation facility outside my allotted time.

I have read this Release and Terms of Agreement and understand all of its terms. I sign it voluntarily and with knowledge of its significance.

Signature/Name of Clients	Date
Parent/Guardian Name (If Client under 19 years of age)	Parent/Guardian Signature (If Client under 19 years of age)

INFORMED CONSENT
WAIVER, RELEASE, AND INDEMNITY
FOR PARTICIPANTS UNDER THE AGE OF NINETEEN (19)

(Read Carefully Before Signing)

BETWEEN: The City of Burnaby (the City)

AND: _____

(Parent and/or Legal Guardian)

This form must be properly completed and executed by the parent or legal guardian of all participants that are under the age of nineteen (19) years at the date of signing.

NOTICE TO PARENT AND/OR LEGAL GUARDIAN

The City of Burnaby requires execution of this document by a parent or legal guardian as a reminder and confirmation of their duty to inform themselves of the risks normal to the activity they have chosen for the child participant and of their responsibility to carefully consider those risks against their personal knowledge of the ability and experience of the child. This is for the protection of the child enrolled, other participants and the City. It does not apply to incidents that arise out of the sole negligence of the City.

PARTICIPANT NAME:_____ (the Participant)

I, THE UNDERSIGNED parent and/or legal guardian of the Participant hereby acknowledge that I have informed myself to my own satisfaction of the risks associated with or inherent in any program or activity offered by the City and in which I have registered the Participant. **I consent** to participation by the Participant in all aspects of the program offered and further agree as follows:

INFECTIOUS DISEASES:

I hereby assume the risk of possible exposure to and illness from infectious or communicable viruses and diseases, by the Participant, including but not limited to SARS-CoV-2, Ebola, influenza, and COVID-19 (collectively, "Transmittable Diseases"), which may be suffered or sustained during the program. I, on behalf of the Participant, knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of the City, or others. Further, I and the Participant agree to comply with all applicable municipal, Provincial, and/or Federal regulations, guidelines, orders, directives or rules, as may relate to minimizing the risk of transmission of any Transmittable Diseases during participation in the Program.

PARENT AND/OR LEGAL GUARDIAN TO INDEMNIFY AND SAVE HARMLESS:

That in consideration of the fee to be paid and instruction or other services to be provided, and excepting only the sole negligence of the City, I hereby agree to Indemnify and Save Harmless the City and its officers, servants, agents, and co-sponsoring organizations from any claims, demands, and causes of action that may arise out of participation by the Participant in the program named below.

PARENT AND/OR LEGAL GUARDIAN TO RELEASE AND WAIVE CLAIMS:

That on behalf of myself, my heirs and assigns, and excepting only the sole negligence of the City, I hereby Release, Waive, and forever discharge the City and its officers, servants, agents, and co-sponsoring organizations, from all claims, costs, causes of action, or demands that may arise out of any incident, accident, or other occurrence that may result in personal or bodily injury, loss of life, property loss, or any other damages to any person by or through participation by the Participant in the program identified below.

DATED THIS_____day of_____, 20_____.

This is the City's standard form of Waiver for participants and cannot be altered.

_____

(Signature of Participant)

_____

(Internal Use Only - Reviewed for Completeness by Staff)