KU RECREATION SERVICES
The University of Kansas

Fit45 Health History

Please fill out all the information below and bring to the ASRFC administrative office, room 103.

Name_____ KUID #_____

Age _____ E-mail_____ Phone_____

Emergency contact name _____ Emergency contact phone_____

Membership type (check one): ☐undergraduate ☐graduate ☐faculty ☐staff ☐affiliate ☐retiree ☐domestic partner ☐spouse

How much time per week do you currently devote to an exercise program? Minutes/Day:_____ Days/Week:_____

What do you hope to achieve by signing up for Fit45? _____

_____

Please list any activities that you are currently doing:

activity	*days per week*	*minutes per session*	*# of months*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have or have you ever had any of the following? (check all that apply)

☐ Heart attack, coronary angioplasty, or cardiac surgery
☐ Lightheadedness or fainting with exercise
☐ Rapid heart beats or palpitations
☐ Pulmonary disease (asthma, emphysema, bronchitis)
☐ High blood pressure
☐ Ankle swelling
☐ Anemia
☐ Chest discomfort, especially with exercise
☐ Shortness of breath with exercise
☐ Phlebitis, emboli (inflammation of a vein, blood clot)
☐ Heart muscle, clicks, or unusual cardiac findings
☐ Stroke
☐ Diabetes
☐ Emotional Disorder
☐ Peripheral arterial disease, claudication (limping due to interference with the blood supply to the legs)
☐ Abnormal blood lipids (evaluated cholesterol and/or triglycerides)
☐ Recent illness, hospitalization or surgical procedure. If yes, what?_____
☐ Taking medication. If yes, what?_____

Injuries

☐ Ankle_____ ☐ Lower Back_____ ☐ Wrist_____
☐ Knee_____ ☐ Back_____ ☐ Elbow_____
☐ Hip_____ ☐ Shoulder_____ ☐ Neck_____
☐ Other_____

Lifestyle

☐ Are you taking supplements (multivitamin, herbal, weight loss/gain, etc.) If yes, what?_____
☐ Drug allergies. If yes, what?_____
☐ Orthopedic problems, arthritis. If yes, what? _____
☐ Do you use caffeine products? If yes, how much?_____
☐ Do you drink alcoholic beverages? If yes, how often, and how much? _____
☐ Do you smoke? If yes, how much?_____

Do you have any family history of the following? (check all that apply)

☐ Coronary Disease ☐ Sudden Death ☐ Abnormal Blood Lipids

Note : Males above 44 years old, females above 54 years old, or those considered high risk are required to obtain a physician's clearance prior to beginning Fit45.

I have read and understand the policies and procedures for participating in training sessions. The information obtained from the heath history form is complete and correct according to my understanding.

Signature:_____ Date:_____

For Office Use Only : Date _____ Received By _____ Receipt # _____

Fit45 Informed Consent

KU THE UNIVERSITY OF KANSAS Recreation Services

Please fill out all the information below and bring to the ASRFC administrative office, room 103.

This consent was executed the _____ day of _____, 20___ at KU Recreations Services, State of Kansas, County of Douglas, by _____ (Client/Releasor).

The Releasor wishes to participate in Fit 45, consisting of fitness testing and progressive exercise programming offered by Recreation Services at the University of Kansas. In consideration for participation of this program, the Releasor agrees to the following:

1. In order to more safely carry on an exercise program, I hereby consent, voluntarily, to exercise tests. I shall perform a Graded Exercise Test (GXT) by riding a cycle ergometer or walking/running on a treadmill, or perform a 3-minute step test. Any GXT will be terminated at any time because of my signs or feelings of fatigue or discomfort, or for any other personal reason.

2. I understand that the risks of this testing procedure may include disorders of heart beats, abnormal blood pressure response, and very rarely, a heart attack. I further understand that selection and supervision of my test is a matter of professional judgment.

3. I understand that skinfold measurements will be taken at three sites to determine percent body fat. I will complete a sit-and-reach test and factors related to low-back function will be evaluated. I will also perform an isometric contraction of the bicep muscle and/or execute as many push-ups and abdominal crunches as possible to determine muscular strength and endurance.

4. I desire such testing to obtain advice and counseling regarding my personal exercise program, but I will understand that the testing does not entirely eliminate risk in the personal training program which I will participate in. In consideration of KU Recreation Services' counseling, I hold the University of Kansas and its employees harmless from any claims due to my participation in the program.

5. I understand that information resulting from my test is strictly confidential.

6. I understand that I can withdraw my consent or discontinue participation in any aspect of the fitness testing or personal training program without penalty upon notification of the Fitness staff.

I have read the clauses above and have had all my questions answered to my satisfaction. For clients that are not of lawful age (16 years or younger), parent or guardian must complete this form.

Date: _____ Signature: _____