



Office of the Vice President for Student Affairs

The Student Recreation & Wellness Center

Wellness Services

Akron, OH 44325-6301

(330) 972-6599

www.zipsrec.uakron.edu

Please follow these procedures prior to participating in the assessment:

1. Please wear comfortable shoes, and comfortable, flexible clothing.
2. Please do not eat or drink at least two (2) hours prior to the test.
3. Please do not exercise excessively twelve (12) hours prior to the test.
4. Please do not drink caffeine at least four (4) hours prior to the test.
5. Please do not smoke two (2) hours prior to the test.
6. Please **DO** take all regular medications prescribed.
7. The physical fitness test takes approximately forty minutes.
8. Please report to Student Recreation and Wellness Center Room 107.
9. **Each SRWC member receives one (1) free assessment per year, each additional assessment is \$15. If you need to cancel your appointment, please do so by calling X6599. Failure to cancel your appointment, will use up your complimentary assessment.**

When you attend the physical fitness assessment, please bring the following information with you:

1. Completed Medical History Form.
2. Completed PAR-Q. If you answered YES to any questions, you must obtain clearance from your physician prior to this assessment.
3. Completed letter from Physician (**ONLY IF YOU ANSWERED YES TO ANY QUESTIONS ON THE PAR-Q**).
4. Read and sign Informed Consent, Release and Medical Authorization.



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List any dietary supplements or over the counter medications you are now taking, including dosages.

List any know drug allergies.

Have you ever been told you have any of the following? Put an X where appropriate.

- | | |
|--|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Thyroid problems |
| How many years ago? _____ | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Abnormal chest x-ray |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke/Aneurysm |
| <input type="checkbox"/> Disease of the arteries | <input type="checkbox"/> Dizziness/fainting |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arthritis |

Do you smoke presently?

 If so, how many cigarettes/cigars/pipes per day?

Are you currently involved in an exercise program?

 If so, are you currently doing an aerobic-type program?
 How often?

 If so, are you currently practicing weight lifting?
 How often?
 What kind?

What activities/exercises would you prefer in a regular exercise program?



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Physical Activity Readiness Questionnaire PAR-Q

For most people physical activity should not pose any problem or hazard. PAR-Q has been designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them. Please read them carefully and check the yes or no opposite the question if it applies to you.

YES NO

1. Has your doctor ever said you have heart trouble?
2. Do you frequently have pains in your heart and chest?
3. Do you often feel faint or have spells of severe dizziness?
4. Has a doctor ever said your blood pressure was too high?
5. Has your doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise, or might be made worse with exercise?
6. Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to?
7. Are you over age 65 and not accustomed to vigorous exercise?

If you answered YES to one or more questions...

You must have written permission from your physician prior to performing any exercise test. Please see attached form.

If you answered NO to all questions...

If you answered PAR-Q accurately, you have reasonable assurance of your present suitability for an exercise test.



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Physician's Exercise Release

Patient Name _____

_____ The above named may participate fully in a physical fitness assessment consisting of cardiovascular, strength and flexibility testing without limitation.

or

_____ The above named may participate in a physical fitness assessment with the following limitations:

Please list any medications that your patient is currently taking that may affect heart rate or blood pressure response to exercise (elevating or suppressing). If none, write "NONE".

Physician's Signature: _____

Print Name: _____

Date: _____



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INFORMED CONSENT, RELEASE, AND MEDICAL AUTHORIZATION

I, _____, knowingly and voluntarily wish to participate in the
print name
following physical fitness test, wellness assessment and/or participation in an exercise
program:

_____.

I acknowledge that the types of physical fitness tests, assessments and /or participation in an exercise program to be performed on me have been fully explained to me. I am in good health and have no physical impairment or any other disability and am taking no medication which would preclude me from participating in the above-mentioned physical fitness test, assessment and /or participation in an exercise program.

I further acknowledge and understand that these tests, assessments and/or participation in an exercise program involve various types of body movement and exercises which include increasing levels of physical workloads and exertion that may involve certain physical risks and hazards including, but not limited to, abnormal blood pressure, fainting, fast or slow or irregular heart rhythm, and in rare instances, heart attack, stroke, or death. Every effort will be made to minimize these risks by evaluation of preliminary information relating to your health or fitness and by observation during testing. I understand and acknowledge that I will provide information requested by the staff regarding my physical condition prior to the administration of the test and/or assessment, and I agree to fully and promptly report my physical status and other such information to the testing staff throughout the exercise test, assessment and/or participation in an exercise program.

I understand that at any time during such test, assessment and/or participation in an exercise program I may stop, especially if I become fatigued or suffer other physical discomfort.

I understand that I may ask any question at any time pertaining to the physical fitness test, assessment and/or participation in an exercise program or the risks associated with the same.

Therefore, I hereby agree as follows:

In consideration for being permitted to participate in the above-mentioned physical fitness test, assessment and/or participation in an exercise program and receive



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educational and other benefits associated with such test, assessment and/or participation in an exercise program and with full knowledge of the potential risks and hazards associated therewith, I hereby voluntarily assume all risk of personal injury and hereby release The University of Akron and its Board of Trustees, its officers, and agents, employees, or students while associated with my participation in such physical testing, assessment and/or participation in an exercise program. In addition, to this release binding me, I agree that this Release will be binding upon my heirs, administrators, executors, and assigns.

In the event of illness or injury associated with my participation in this physical fitness testing, assessment and/or participation in an exercise program, I hereby give my consent and authorization for (1) the administration of emergency first aid care and treatment by faculty or staff members of The University of Akron, (2) the administration of any medical treatment deemed necessary by licensed physician, and/or (3) the transfer to any reasonably accessible hospital. This authorization is not intended to cover major surgery unless the medial opinions of two licensed physicians, concurring in the necessity for such surgery, are obtained prior to performance of such surgery.

By signing this Release, I hereby certify that I have read and fully understand the above conditions and agree to be legally bound by this Release.

READ CAREFULLY BEFORE SIGNING.

Name Date

Address
