Print Form

L.I.F.E.

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Preferred Phone Number :(_____) _____ Email: _____

Address: _____

_____

Date of Birth: _____ _____ Gender: MALE FEMALE

Marital Status: ☐ Single ☐ Married ☐ Widowed

Assess your health by marking all true statements

You have had:

___ a heart attack
___ heart failure
___ cardiac arrhythmia
___ known heart murmur
___ congenital heart disease
___ any heart surgery
___ coronary angioplasty
___ heart palpitations

You have:

___ experienced chest pain with mild exertion
___ experienced dizziness, fainting, or blackouts with mild exertion
___ experienced unusual fatigue or shortness of breath during usual activities
___ been prescribed heart medications (please indicate):_____

Check all that apply:

___ you smoke
___ your blood pressure is greater than 140/90
___ you take blood pressure medication
___ you are a diabetic or take medicine to control your blood sugar
___ you have high cholesterol >200 (or HDL < 35 mg/dL or LDL > 169 mg/dL)
___ you have a close blood relative who had a heart attack before age 55 (father/brother) or age 65 (mother/sister)
___ Bone/Joint problem
___ Recent injury/surgery
___ low back pain
___ Other (specify) _____

Please list all medications you are currently taking:

Please list any assistive devices such as hearing aids, canes, walker etc:

Please list any physical limitations/concerns that may interfere with your exercise program (i.e. arthritis, orthopedic concerns, recent surgery):

WAIVER AND SIGNATURES

I have answered the questions accurately and correctly. I understand that my medical history is an important factor in the development of my exercise and fitness program. Medicine is not an exact science and no guarantees can be made as to the safety of exercise activities. I understand that known, unknown or undisclosed medical or physical conditions may result in injury. I knowingly and willingly assume all risks, and I hereby release The Department of Wellness and Recreation, The University of Miami, its agents and employees from any and all liability, damage, or loss arising of/or resulting from my participation in this program, especially including any negligence of the University's part.

Participants Signature Date

Witness Date

wellness center
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L.I.F.E PROGRAM

Physical Clearance Form

(please present this form with the next page to your physician)

Dear Doctor:

Your patient _____ is interested in participating in the LIFE Program for seniors at the University of Miami Wellness Center. The program focuses on maintaining and increasing flexibility, muscular strength and decreasing the risk/fear of falling. Exercises include light/moderate resistance training (10 exercise circuit,1 set of 12-15 reps), stretching, functional balance and agility exercises and walking. Our program is supervised by trained individuals with degrees in Exercise Physiology and/or certification through the American College of Sports Medicine.

Due to the age and potential risk factors of your patient, we require your permission to allow him/her to participate in the program. If you would allow this patient to participate in our program, please fill out the form on the next page. If you have any additional questions, please contact me at (305) 284-8503.

Sincerely,

Tony Musto, Ph.D.
Associate Director, Fitness Programs
ACSM Exercise Specialist

University of Miami Wellness Center
Physician's Statement and Clearance Form

At the University of Miami Wellness Center, your safety is our primary concern. For that reason, we comply with the health and fitness standards of the American College of Sports Medicine.

On the Physical Activity Readiness Questionnaire (PAR-Q) or health screening you just completed, you identified that you have one or more coronary and/or other medical risk factors which may impair your ability to exercise safely and/or increase the risk(s) involved with fitness testing. For this reason, you need to have your physician complete and return this medical clearance form before you can participate in our program.

We recognize that you are eager to start your fitness program and we sincerely regret any inconvenience that this may cause you. However, please keep in mind that we want your experience at the Wellness Center to be as safe as possible. In order to expedite this process, we will gladly fax this form directly to the physician of your choice. If the doctor is aware of your medical history, s/he may be able to complete the form and fax it right back to us. In many cases, the delay is only one day.

I hereby give my physician permission to release any pertinent medical information from any medical records to the staff at the University of Miami Wellness Center. All information will be kept confidential.

Patient's signature_____ Date_____

Physician's name_____Phone_____Fax_____

Wellness Center Staff Use Only

Information requested for_____Date requested_____

Reason for requesting medical clearance_____

For Physician's Use Only

Please check one of the following statements:

- ☐ I concur with my patient's participation in an exercise program/fitness testing with no restrictions.
- ☐ I concur with my patient's participation in an exercise program if s/he restricts activity to:

  _____

- ☐ I do not concur with my patient's participation in an exercise program (if this box is checked your patient will not be allowed to participate).

  Reason_____

Physician's name (type or print) _____

Physician's signature_____ Date_____

Please return or fax to:
Tony Musto, Ph.D.
ACSM Clinical Exercise Specialist
Associate Director, Fitness Programs
Fax # (305) 284-8517

Rules of the game

1. I understand that as a L.I.F.E. Program member, I only have access to the Wellness Center on Monday, Wednesday, Friday from 7 am to 8 am, 8 to 9am or 9 am to 10 am. *_____

2. I understand that I must show my L.I.F.E. access card to a front desk employee in order to gain entrance into the Wellness Center each time I use the facility. _____

3. I understand that if I do not attend the L.I.F.E. program for 2 weeks without notifying a staff member my place may be lost to a participant on the waiting list. _____

4. I understand that I may be denied participation in the program at any time due to physical, health, or any other concerns in which the professional staff is not qualified to address and/or the L.I.F.E. program is not appropriate. _____

5. I understand that upon completion of 36 visits my L.I.F.E. membership is expired; however, I do have the opportunity to renew my membership for an additional 36 visits. _____

6. I understand that I have 16 weeks to complete my 36 visits unless an extension is approved by Wellness Center staff. _____

*Does not include those with a regular Wellness Center Membership.

_____ _____
Participant's signature Date

_____ _____
Print Name Date

_____ _____
Witness Date

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LIFE PROGRAM
INFORMED CONSENT AND RELEASE FORM

The participant understands that the LIFE Program involves activities to develop strength and endurance, aerobic capacity, flexibility, balance, and coordination. Activities include low to moderate resistance training and flexibility exercises. Resistance training includes a ten-exercise circuit consisting of one set of 12-15 repetitions.

Although participants are encouraged to proceed at their own pace, as with all exercise, some risk of injury is present. The participant has been informed that exercise may cause abnormal blood pressure, fainting, disorders of heartbeat, and in rare instances a heart attack. **The participant understands that if symptoms indicating an abnormality or distress such as fatigue, dizziness, shortness of breath, or chest pain appear they will stop exercising and report these to an instructor.** The participant understands that they may stop their exercise at any time for any reason.

The participant has been informed that there will not be a physician present during any of the exercise. The participant will have to be taken to a hospital if they develop the need for any emergency care, with the understanding that it will take time to travel from exercise site to the hospital. The participant further understands that, should such difficulties occur, the delay in time could be detrimental to them. The participant also understands that they are responsible for any medical expenses that they may incur as a result of illness or injury.

The participant understands that the practice of exercise science and the methods concerning these exercise classes are not an exact science and acknowledges that no guarantee or assurance has been given to the results of the exercises.

The participant understands that participation in the program is voluntary and that they may withdrawal from the program at any time.

The participant understands that all data collected may be used for research purposes but will not be linked to their identity. Participant records will be kept confidential to the extent permitted by law.

Participation in the LIFE Program and utilization of the University of Miami Wellness Center is at the participant's sole discretion, judgment and own risk. The participant assumes all risks of participating in the LIFE Program. The participant waives, releases, and discharges University of Miami, its board of trustees, the Department of Wellness and Recreation, and their employees and representatives from claims, actions, damages, liability and negligence for personal injury or damage relating to their participation in the LIFE Program and/or use of the University of Miami Student Wellness Center.

The participant, being mindful of his/her age, health and physical condition, agrees to voluntarily participate in the L.I.F.E Program for seniors. The participant has read the Informed Consent and Release Form, and understands and agrees with its content. The participant has had an opportunity to ask any questions they may have regarding the LIFE Program, and any questions have been answered to the participant's satisfaction.

_____ _____

Participant's signature Date

_____ _____

Print Name Date

_____ _____

Witness Date