



Children's PAR-Q

Physical Activity Readiness Questionnaire

PARTICIPANT INFORMATION

Name: _____ Age: _____ Gender: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____
 Emergency Contact: _____ Phone: _____

MEDICAL HISTORY and PHYSICAL ACTIVITY

	No	Yes
Has a doctor ever said your child has a heart condition and recommended only medically supervised activity?	_____	_____
Does your child have chest pain brought on by physical activity?	_____	_____
Do your child have a bone or joint problem that could be aggravated by the proposed physical activity?	_____	_____
Has a doctor ever recommended medication for your blood pressure or a heart condition?	_____	_____
Are you aware, through your own experiences or a doctor's advice, of any other physical reason against your child exercising without medical supervision?	_____	_____

Has a physician ever diagnosed your child with one of the following? Check all that apply.

- | | | | |
|--------------------|---------------------|------------------|--------------------|
| Heart Condition | Rheumatism | High Cholesterol | Sacroiliac Problem |
| Diabetes | Hernia | Epilepsy | Knee Problem |
| Asthma | Recent Surgery | Stroke | Back Problem |
| Short of Breath | Angina | Hypoglycemia | Neck Problem |
| Arthritis Bursitis | High Blood Pressure | Emphysema | Pregnancy |

Other: _____

Date of last physical exam: _____

Please list all of your child's current medications: _____

Notes: _____

PHYSICAL ACTIVITY

Does your child exercise regularly? _____ If yes, how often? _____

If your child is not currently exercising, has she/he exercised in the past? _____

What are your child's exercise goals? _____

I certify that my child is in good health and that I have truthfully completed this Health History Questionnaire.

Parent/Legal Guardian Signature

Date



Youth Fitness Center Orientation Registration and Liability Form

Participant Information

Name: _____ Age: _____ Gender: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____
Emergency Contact: _____ Phone: _____

Parent/Legal Guardian Information

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____

For individuals, youth orientations are scheduled by appointment:

Call Will Boyle at (314) 442-3494 to make arrangements with a certified personal trainer.

Location: Marilyn Fox Building Fitness Center

Registration Fee: Free

****Registration must be received
one-week prior to the class or appointment date to
conduct the youth orientation.****

Mail or return to:
JCC, Marilyn Fox Building
16801 Baxter Road
Chesterfield, MO 63005
Attn: Will Boyle

Participant's Signature: _____ Date: _____

Parent/Legal Guardian: _____ Date: _____



Physician Release Form

Date: _____

Dear Physician,

Your patient, _____ wishes participate/continue in a personalized exercise program with the Jewish Community Center Personal Training Department. As a participant in this program, your patient will be instructed in proper exercise techniques working one on one with a Nationally Certified Personal Trainer.

All of our personal trainers will follow the American College of Sports Medicine (ACSM) guidelines for exercise testing and prescription. Their guidelines in short will be as follows. If you wish to see a specific workout for your patient please contact the office.

	Cardiovascular Fitness	Muscular Fitness
Frequency	3-5 days/week	At least 2 days/week
Intensity	60-75% Max Heart Rate	Moderate Resistance
Duration	20-60 minutes	Approximately one hour
Mode of Activity	Aerobic exercise	Strength training major muscle groups

Are there any medical factors in your patient's history, or any medications that are currently being taken which would affect exercise programming or the patient's ability to participate in a non-medically supervised exercise program? Please Circle: Yes No

If yes, please explain: _____

Please identify any recommendations or restrictions that are appropriate for your patient in this exercise program:

Please document any developmental, cognitive, and/or physical disabilities and identify any recommendations, restrictions or limitations that are appropriate for your patient in this exercise program:

My patient, _____ has my approval to begin/continue an exercise program with the Jewish Community Center Personal Training Department with the recommendations or restrictions stated above.

Physicians name/phone number

Physician's Signature

Thank You,
Will Boyle

Asst. Director, Fitness & Membership

Jewish Community Center
16801 Baxter Road
Chesterfield, MO 63005
Phone & Fax: (314) 442-3494

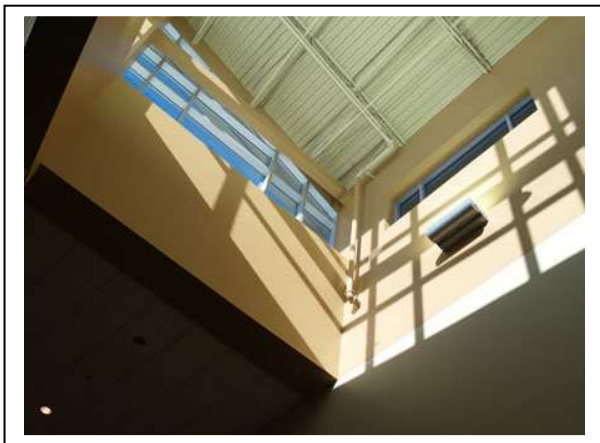
Please Fax or Mail this form, attention Will Boyle, to the fax number or address listed above. If you have any questions feel free to contact Will, Jewish Community Center Fitness Manager, at (314) 442-3494.

Youth Fitness Center Orientation

(Mandatory for all 12 - 16 year olds)

This 1-hour course, taught by a Nationally Certified Personal Trainer, will teach youth between the ages of 12 and 16 how to safely and effectively utilize the cardiovascular and strength equipment in the JCC's Fitness Centers.

This class is mandatory for all 12 - 16 year olds who would like to work out in the JCC's fitness centers.



Youth will learn the following:

- ▶ Benefits of exercise
- ▶ How to develop a safe and effective strength and conditioning program
- ▶ Guidelines for using the free weights and strength training machines
- ▶ General fitness recommendations
- ▶ Rules of the Fitness Center

Cost: Free

Location: Marilyn Fox Building Fitness Center

-By appointment-

REGISTRATION FORMS ARE DUE ONE WEEK PRIOR TO THE APPOINTMENT DATE

For more information call Will Boyle at (314) 442-3494.

Pre-registration is required. To register, please complete the following information and return to JCC – Fox Building, 16801 Baxter Road, Chesterfield, MO 63005

Attention: Will Boyle

Dear Parent,

Thank you for your interest in the JCC Youth Fitness Center Orientation. This is a great opportunity for your child to learn the importance of exercise and strength training, as well as how to exercise safely and effectively.

Please complete the attached registration/liability form and health history questionnaire. A physician's release form is also included. **Your child must be cleared by his/her physician before participating in the program.** Once all forms are completed, please return them directly to me.

Thank you for your interest and please do not hesitate to contact me at (314) 442-3494 if you have any questions.

Sincerely,

Will Boyle
Assistant Director, Fitness & Membership