



**TYENDINAGA FITNESS RESOURCE CENTRE  
(613) 962-2822  
REGISTRATION FORM**

TFRC Member ID # _____
------------------------

Name: \_\_\_\_\_ Birth date (mm/dd/yyyy): \_\_\_\_\_

Referred By: \_\_\_\_\_ First Nation Status: Yes  No

**Full Mailing Address:**

\_\_\_\_\_

Province: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Do you require the following for your success in being active?**

Personal Trainer Yes  No

Emergency Contact: \_\_\_\_\_

Telephone: \_\_\_\_\_

**Medical:** If you have any medical concerns/injuries that may affect your exercise experience, please provide details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRIVACY STATEMENT:**

At the time of registration, the Tyendinaga Fitness Resource Centre collects personal information from you for the purposes of: understanding your fitness needs and objectives, to process your membership to the TFRC, obtaining a photograph for use on membership identification and to inform you about our services and programs. This personal information is maintained and securely stored to protect your privacy from being compromised. Each of our employees is responsible for maintaining the confidentiality and security of all personal information to which they have access. Your knowledge and consent are required for the collection, use, or disclosure of your personal information. By signing below, you consent to the use of your personal information for the purposes listed above. You may refuse or withdraw your consent at any time; however, we may not then be able to provide you with our full range of services

Client Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**PLEASE WEAR INDOOR SHOES & COMFORTABLE CLOTHING**

**WAIVER:**

- ACKNOWLEDGE, agree and that I understand the nature of the Tyendinaga Fitness Resource Centre (TFRC), based on that I am qualified, in good health and in proper physical condition to participate in activities in the TFRC.
- FULLY UNDERSTAND that: a) physical activity involve risks and dangers to bodily injuries; b) that these risks and dangers may be caused by my own actions or inactions; c) there may be other risks and losses either not known by me or not readily foreseeable at this time, and I FULLY ACCEPT AND ASSUME ALL RISKS AND ALL RESPONSIBILITY FOR LOSSES, COSTS AND DAMAGES I incur as a result of my participation in the activities.
- AGREE AND WARRANT that I will examine and take into consideration each Activity in which I take part in as a member and that if I observe any condition which I consider to be unacceptable or dangerous, I will notify the proper authority in charge of the Activity.
- HEREBY RELEASE, discharge and covenant not to sue the Tyendinaga Fitness Resource Centre, their administrators, directors, agents, officers, volunteers or employees, any sponsors, advertisers, and if applicable, owners and lessors of premises, on which the Activity takes place (each considered on the Releases herein) from all liability, claims, demands, losses or damages on my account caused or allege to be caused in part by negligence of the Releases or otherwise, and that I further agree that if, despite this release and waiver of liability, assumption of risk, and indemnity agreement, I, or anyone on my behalf, makes a claim against any of the Releases, I WILL INDEMNIFY SAVE AND HOLD HARMLESS each of the Releases, from any litigation's expenses, attorney fees, loss, liability, damage, or cost which any may incur as a result of such claim.
- I have read this agreement, fully understand its terms, understand that I have given up substantial rights by signing it and have signed it freely and without any inducement or assurance of any nature and intend it be a complete and unconditional release of all liability to the greatest extent allowed by law and agree that if any portion of this agreement is held to be invalid, the balance, notwithstanding, shall continue in full force and effect.

Client Name (print): \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature (only if age 18 or over)

**PARENTAL CONSENT (if applicable)**

AND I, the minor's parent and/or legal guardian, understand the nature of activities and the minor's experience and capabilities and believe the minor to be qualified to participate in such activities. I hereby release, discharge, covenant not to sue, and AGREE TO INDEMNIFY AND SAVE AND HOLD HARMLESS each of the Releases from all liability, claims, demands, losses, or damages on the minor's account caused or alleged to be caused in whole or part by the operations, and further agree that if, despite this release, I, the minor, or anyone on the minor's behalf makes a claim against any of the above Releases, I WILL INDEMNIFY, SAVE AND HOLD HARMLESS each of the Releases from any litigation expenses, attorney fees, loss liability, damage, or cost any may incur as the result of any such claim.

Name of Parent/Guardian(print): \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature (only if participant is under the age of 18):  
\_\_\_\_\_

**OFFICE USE ONLY**

1. Single  Student  Senior

2. Monthly Payment  Yearly Payment  Drop In

3. Payment Method:

Cash  Debit  Cheque  Gift Certificate  Donation  Guest Pass

Signature of TFRC Employee \_\_\_\_\_ Date \_\_\_\_\_

# 2022 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 <input type="checkbox"/> OR high blood pressure <input type="checkbox"/> ?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
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).	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
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: _____	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your doctor ever said that you should only do medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>

**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](http://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.

# 2022 PAR-Q+

## 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 chemotherapy 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.

### 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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