THE SF GAMES – SUMMER 2020

July 15 – August 18

Create your permanent customized camp schedule using the day options provided below. Once your camp schedule is chosen, your schedule remains consistent throughout the duration of the camp.

Please submit your completed camp form to Facebook.com/SarahFechterFitness inbox or in person at our store front during open hours of operation.

Name: _____ Date: _____

Outdoor / SF Games -select which days you will be attending

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
◻ 6:30pm	◻ 5:30am	◻ 6:30pm	◻ 5:30am	◻ 6:30pm	◻ 5:30am

◻ 3 days/week- $199

◻ Add a 4th day for a flat rate - $60

Camp registration forms required for participation.

Once your camp schedule is chosen, your schedule remains consistent throughout the duration of the camp.

This section for STAFF only –

Payment: CC: _____ CK#: _____ Cash: _____

Due at time of Registration:

- ✓ Staff ____ [Initial certifies that staff has completed payment AND e-mailed camper all information]
- ✓ Staff ____ [Initial certifies that camper has received SF Games T-shirt]

HEALTH & FITNESS CLIENT REGISTRATION

Today's Date: _____

Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Gender: _____ How did you hear about camp: _____

Birth Date: _____ Are you a Fitness Instructor: _____

Occupation: _____ Email: _____

Emergency Contact Name: _____ Phone: _____

PHYSICIAN INFORMATION

Primary Care Physician Name: _____

Address: _____

Phone Number: _____

CONSENT FOR SERVICES

I hereby authorize Sarah Fechter Fitness to provide me with professional fitness services. I give my consent for Sarah Fechter Fitness to obtain and examine personal medical information, if warranted. I understand that any medical information received will only be used under HIPPA privacy regulations.

_____ _____

Client Signature **Date**

_____

Client Printed Name

Sarah Fechter Fitness, LLC

ACSM Assumption of Risk, Contract Agreement, and Registration

Congratulations on your decision to participate in our program! With the help of your coach and our qualified staff, you greatly improve your ability to accomplish your training goals faster, safer, and with maximum benefits.

As with any exercise program, there are risks, including but not limited to, increased heart stress and the chance of musculoskeletal injuries. In choosing to participate in this program, you agree to assume responsibility for these risks and waive any possibility for personal damage. You also agree that, to your knowledge, you have no limiting physical conditions or disability that would preclude an exercise program.

A physician's examination is required to all participants if appointed by staff. By signing below, you accept full responsibility for your own health and well-being and you acknowledge and understand that no responsibility is assumed by Sarah Fechter, Sarah Fechter Fitness, LLC, or any or all Sarah Fechter Fitness employees or representatives.

Please place an X next to any of the ACSM's coronary artery disease risk factors that pertain to you. I understand that Sarah Fechter Fitness requires a medical clearance for anyone with more than one of the following risk factors.

_____ **Family History**: Myocardial infarction (heart attack), coronary revascularization, or sudden death before 55 years of age in father or other male first degree relative (brother, son), or before 65 years of age in mother or other female first degree relative (sister, daughter)

_____ **Cigarette Smoking:** Current cigarette smokers or those who quit within previous 6 months.

_____ **Hypertension:** Systolic blood pressure ≥140 mmHg or diastolic ≥90 mmHg, confirmed by measurements on at least 2 separate occasions, or on anti-hypertensive medication.

_____ **Hypercholesterolemia:** Total serum cholesterol >200mg/dl or high-density lipoprotein cholesterol of <35 mg/dl, or on lipid-lowering medication.

_____ **Impaired Fasting Glucose (diabetes mellitus):** Fasting blood glucose of ≥110 mg/dl confirmed by measurements on at least 2 separate occasions.

_____ **Obesity:** Body Mass Index of ≥30 kg/m2 or waist girth of >100cm

_____ **Sedentary Lifestyle:** Persons not participating in a regular exercise program or meeting the minimal physical activity recommendations from the U.S. Surgeon General's report (accumulating 30 minutes or more of moderate physical activity on most days of the week)

_____ **I have none of the above listed Risk Factors**

If you checked more than one of the risk factors above your physician must fill out and sign the Physician's Approval form located in the new client packet prior to beginning your training sessions.

By signing below I verify that I have read all of the above statements and the information I have provided is accurate.

Signature: _____ Date: _____

Printed Name: _____

Name: _____ Date of Birth: _____ Age: _____

Gender: Male Female Height: _____ Weight (lbs): _____

I. PAST MEDICAL HISTORY

A. Hospitalizations and Surgeries:

_____
_____
_____
_____

B. Present Medications (prescription and over-the-counter):

Name Dose #Taken Daily Reason

_____
_____
_____
_____
_____

Herbs and Supplements

_____
_____

C. Current Health:

List all conditions for which you are currently under a physician's care:

_____
_____
_____

II. LIFESTYLE HISTORY

A. smoker(currently) □ ex-smoker □ nonsmoker □ chewing tobacco □
If a smoker, number of packs (pipes, cigars) per day: _____
How long have you smoked? _____ If ex-smoker, when did you quit? _____

B. Alcohol intake:
What do you usually drink? _____ How much? _____ How often? ____
Do not drink alcohol □

C. Exercise:
Do you exercise regularly? _____ What activity? _____
How often? _____ How long is each session? _____

D. Stress level:
None □ Moderate □ High □ Very High □

E. Diet-Check any foods that you **AVOID** in your diet:
Salt □ Sugar □ Fats (oils) □ Red meat □ Eggs □ Poultry □ Wheat □ Caffeine □

F. Usual number of meals per day: ____ Number of times per week you eat "fast foods" _____

G. Usual number of cola or soda pop beverages per week ___X ___ oz. With caffeine ____

AHA/ACSM Health/Fitness Facility Participation Screening Questionnaire

Assess your health needs by marking all true statements.

History

You have had:

- ☐ A heart attack
- ☐ Heart Surgery
- ☐ Cardiac catheterization
- ☐ Coronary angioplasty (PTCA)
- ☐ Pacemaker, implantable defibrillator, or heart rhythm disturbance
- ☐ Heart valve disease
- ☐ Heart failure
- ☐ Heart transplantation
- ☐ Congenital heart disease

Symptoms

- ☐ You experience chest discomfort with exertion
- ☐ You experience unreasonable breathlessness
- ☐ You experience dizziness, fainting, or blackouts
- ☐ You take heart medications

Other Health Issues

- ☐ You have musculoskeletal problems
- ☐ You have concerns about the safety of exercise
- ☐ You take prescription medications
- ☐ You are pregnant
- ☐ You have asthma (Inhaler should be with you at all times)

If you marked any of the statements in this section, consult with your health care provider before engaging in an exercise program. You may need to use a facility with a **medically qualified staff member** to guide your exercise program

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Cardiovascular Risk Factors

- ☐ You are a man ≥ 45 years old
- ☐ You are a woman ≥ 55 years old, you have had a Hysterectomy or you are postmenopausal
- ☐ You Smoke
- ☐ Your BP is ≥ 140/90
- ☐ Your blood cholesterol is ≥ 200 mg/dl
- ☐ You don't know your cholesterol level
- ☐ You have a close relative who had a heart attack before age 55 (male) or 65 (female)
- ☐ You are diabetic, or take medication to control blood sugar
- ☐ You are physically inactive

If you marked two or more of the statements in this section, consult with your health care provider before engaging in an exercise program. You may need to use a facility with a **professionally qualified staff member** to guide your exercise program

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- ☐ None of the above are true

You should be able to exercise safely without consulting your health care provider in almost any exercise facility that meets your needs.

III. REVIEW OF SYMPTOMS

In the past, have you been diagnosed as having any of the following symptoms or conditions? Check the (S) box for yourself, (P) box if a parent has had the condition or (R) box if another relative has had condition.

Condition/Symptom	S	P	R	Condition/Symptom	S	P	R
Heart Disease				Unusual Weight Loss/Gain			
Heart Surgery				Hormone Disorder			
Cardiac Catheterization				Unusual Fatigue			
Pacemaker				Stroke			
Defibrillator				Blood Clots			
Heart Valve Disease				Arthritis			
Chest Pain During Exercise				Bone or Joint Problems			
Shortness Of Breath				Lung Disease			
Dizziness				Asthma			
Fainting				Emphysema			
Burning During Exercise				Bronchitis			
High Blood Pressure				Anemia			
High Cholesterol				Cancer			
Diabetes				Osteoporosis			
Sleep Apnea				Abnormal Pregnancy			
Swollen Ankles				Psychological Disorder			
Heart Palpitations				Eating Disorder			
Heart Murmur				Neurological Disorder			

Describe any boxes that are checked:

_____

_____

_____

_____

List any other problems not mentioned above:

_____

_____

_____

_____

IV. Exercise History

Describe your regular participation in the following areas:

A. Aerobic Exercise _____

B. Strength Exercise _____

C. Flexibility Exercise _____

D. Other Activities _____

V. Goals

Please list and describe what benefits you are anticipating with this program. Discuss the specific health or fitness improvements you hope to make.

Declaration:

I have read and fully understand the questionnaire and confirm that, to the best of my knowledge, the answers given by me are correct and accurate. I know of no reason why I should not participate in any physical exercise or any such activity suggested to me by Sarah Fechter. I agree to notify Sarah Fechter of any future changes to the above answers before continuing exercise. I acknowledge that any suggestions from any such employee or representative regarding exercise, nutrition, and/or healthcare are neither diagnostic nor prescriptive.

Waiver Release:

I hereby release Sarah Fechter, Sarah Fechter Fitness LLC, Heritage High School, Saginaw Township Parks and Recreation, Saginaw County Parks and Recreation, and their assistants, interns, members, officers, directors, employees, representatives, and assigns from and against any and all liabilities, claims, action, cause of actions, and/or damages from or relating in any way to any injury or other damage I may sustain while testing, preparing for, or otherwise participating in or following, any stretching, aerobic, strength training, physical exercises or other activities or recommendations while participating in this exercise program.

I understand that I may be required to perform a physical assessment and/or complete several questionnaires with a personal trainer, fitness specialist, or other assigned professionals prior to participating in the program. I acknowledge that all of the information provided by me has been true and complete. In addition, I acknowledge that all of the prior testing and/or questioning were undertaken solely for informational purposes. Testing, questioning and/or the results, nor the personal fitness program prepared for me, declare or otherwise affirm my fitness ability, or lack of fitness ability, for participation in the program.

Client Signature _____ Date _____

Witness Signature _____ Date _____

Assumption of Risk, Covenant Not to Sue and Release Form

I, _____ recognize that participating in Sarah Fechter Fitness SF Games/Camp, TRX® , Spinning® , Spin® , Club SF, Step Aerobics, Ass-thetics, Metabolic Conditioning, Circuits, Yoga, Mobility, Boxing, Barbells, Strength fitness classes, all other group exercise classes, Youth Programs, Personal Training and Small Group Training sessions, and or any other instructions or activities at Sarah Fechter Fitness Studio present certain risks and dangers. These risks include personal injury, the loss or damage of personal property, and loss of life.

Use of sauna is at your own risk: If you become uncomfortable, dizzy, sleepy or overheated exit immediately. Supervise children at all times. Check with a doctor before using if pregnant, in poor health, or under medical care. Breathing heater air in conjunction with consumption of alcohol, drugs, or medications is capable of causing unconsciousness.

Therefore, it is agreed as follows:

That in consideration of being allowed to participate in various Sarah Fechter Fitness activities and receive educational and other benefits the undersigned hereby voluntarily assumes all risk of accident and/or damage to his/her person or property and all risks of any kind sustained, whether caused by negligence of Sarah Fechter Fitness studio, its officers, employees and agents, game officials, volunteers, and all participating sponsors (hereafter releases). The releases shall assume no responsibility or liability for me for accident, illness, or loss or damage of personal property, and I acknowledge ad do hereby assume all risks inherent in the use of Sarah Fechter Fitness studio's facilities and in connection with these activities, and for myself, heirs, executors, administrator and assigns do hereby expressly agree not to sue and release and discharge the releases from all claims, demands, liability actions or judgments of any king whether caused by the negligence of said releases or otherwise, which I now have, or may have in the future against any of the said releases arising out of my fitness participation.

I know of no reason why I should not participate in any physical exercise or any such activity suggested to me by Sarah Fechter Fitness or its employees. I agree to notify Sarah Fechter Fitness of any future changes to my health before continuing exercise. I acknowledge that any suggestions from any such employee and/or representative regarding exercise, nutrition, or healthcare are neither diagnostic nor prescriptive.

I also agree to abide by all policies and procedures of Sarah Fechter Fitness Studio and will follow instructions and requests of the releases.

I understand by voluntarily signing this release hereby certifies that I have read and fully understood the conditions herein provided.

Applicants Signature: _____ Date: _____/_____/_____

If applicant is a minor:
Parent/Guardian Signature: _____ Date: ____/_____/_____

Witness Signature: _____ Date: ____/_____/_____
(STAFF) [Signature certifies that staff has completed payment AND e-mailed camper all information]