



**STUDENT WELLNESS CENTER**

Broward Campuses

*-Train Your Body - Train Your Mind*

**PLEASE COMPLETE LEGIBLY IN INK!**

STAFF NOTES

**Personal Information**

First and Last Name: \_\_\_\_\_ FAU Z#   Z   I do not have a Z # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender M F

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail (FAU preferred) \_\_\_\_\_ I do not have e-mail \_\_\_\_\_

Please check here if you *do not* wish to receive e-mails about Wellness Center happenings. \_\_\_\_\_

Do you have a disability that you would like to disclose? \_\_\_\_\_

If so, do you have any reasonable requests for accommodations? \_\_\_\_\_

**Emergency Contact Information**

Name \_\_\_\_\_ Phone \_\_\_\_\_

**Membership Classification**

*For Staff Use: FEE MEMO - Not Needed Given Visiting/Did not want Other: \_\_\_\_\_*

FAU Student \_\_\_\_\_ FAU Police \_\_\_\_\_ FAU Faculty <sup>\*FAU/BCC</sup> \_\_\_\_\_ FAU Staff <sup>\*FAU/BCC</sup> \_\_\_\_\_ BCC <sup>\*FAU/BCC</sup> \_\_\_\_\_

FAU Former or <sup>\*NON</sup> FAU/BCC Future Student \_\_\_\_\_ Nova <sup>\*NON</sup> FAU/BCC \_\_\_\_\_ FIU <sup>\*NON</sup> FAU/BCC \_\_\_\_\_ UF extension <sup>\*NON</sup> FAU/BCC \_\_\_\_\_ Member Family/Friend \_\_\_\_\_ Community <sup>\*NON</sup> FAU/BCC \_\_\_\_\_

**Referral Source** *How did you hear about us?*

Bulletin \_\_\_\_\_ Orientation \_\_\_\_\_ Board \_\_\_\_\_ \*Member \_\_\_\_\_ Faculty \_\_\_\_\_ Staff \_\_\_\_\_ Website \_\_\_\_\_ Walk-In \_\_\_\_\_

**\*List your friends name so (s)he can be entered to get a giveaway:**

**Interests**

Please check everything listed below that you would be interested in receiving information about or participating in:

**Appointments**

Fitness Evaluation \_\_\_\_\_ Exercise Programming \_\_\_\_\_

**Intramurals and Classes**

Basketball \_\_\_\_\_ Fitness Kick Boxing \_\_\_\_\_ Flag Football \_\_\_\_\_ Home Workouts (DVD/video/books) \_\_\_\_\_ Martial Arts \_\_\_\_\_

Pilates \_\_\_\_\_ Soccer \_\_\_\_\_ Ultimate Frisbee \_\_\_\_\_ Weight Management \_\_\_\_\_ Yoga \_\_\_\_\_

## Pre-Participation Screening Questionnaire

The purpose of pre-participation screening is to attempt to identify those at risk for an adverse event during exercise and those who should undergo an appropriate medical evaluation before starting an exercise program. Screening also identifies persons with known disease or special medical needs who should ideally participate, at least initially, in a medically supervised program. This questionnaire is based on ACSM guidelines.

### BOX 1

- \*  Your doctor has said that you have a heart condition. **Specify:** \_\_\_\_\_
- \*  You feel pain in your chest when you do physical activity.
- \*  In the past month, you had chest pain while you were not doing physical activity.
- \*  You lose your balance because of dizziness or you lose consciousness.
- \*  You have a bone or joint problem that could be made **worse by a change in your physical activity.**  
**Specify:** \_\_\_\_\_
- \*  Your doctor is currently prescribing medication for a heart condition. **List medication:** \_\_\_\_\_
- \*  You have asthma or other lung disease or you experience unreasonable breathlessness.  
**Specify:** \_\_\_\_\_
- \*  You have diabetes.  
 You are taking medication to control diabetes. **List medication** \_\_\_\_\_
- You have burning or cramping in your lower legs when walking short distances.
- You are pregnant.
- You have concerns about the safety of exercise.
- You are over 69 years of age, and you are not used to being very active.
- You know of any other reason why **you should not do physical activity**. List any other health concerns and/or medications and their purpose which may **limit your ability to participate in exercise**:

**Total number checked in BOX 1**

If you checked any statements in BOX 1, you should consult your physician before engaging in exercise. A **medical consent form** is **required** to participate in the Wellness Center facilities and programs. You may need to use a facility that has medically qualified staff. **Please note: the FAU Davie Wellness Center is not a medically supervised facility.**

*\*STAFF IF MEDICAL CONSENT IS NEEDED, GIVE A COPY OF THIS QUESTIONNAIRE AND A MEDICAL CONSENT FORM (COPY OF THIS QUESTIONNAIRE GIVEN Y/N FORM GIVEN Y/N)*

### BOX 2

- \*  You have a family history of heart disease: Example: Heart attack in father/brother before 55 or mother/sister before 65.
- \*  You have high blood pressure (greater than 140/90). **List average blood pressure** \_\_\_\_\_
- \*  You are taking blood pressure medication. **List medication:** \_\_\_\_\_
- \*  You have high cholesterol (greater than 200mg/dl).
- \*  You are taking cholesterol medication. **List medication:** \_\_\_\_\_
- \*  You have impaired fasting glucose  $\geq 100$  mg/dl.
- \*  You are obese (waist > 40 inches or more than 20 pounds overweight, for example).
- \*  You are physically inactive (i.e., you get less than 30 minutes of physical activity on at least 3 days per week).
- \*  You still smoke or smoked within last 6 months.
- You are a man older than 45 years OR a woman older than 55 years or had a hysterectomy or are postmenopausal.

**Total number checked in BOX 2**

- \*  You have high HDL (good cholesterol) >60 mg/dl.  
 **Adjusted Total in BOX 2** (Subtract one risk factor from the previous total if high HDL is checked.)

If your adjusted total is **two or more** statements in BOX 2, you should consult your physician before engaging in exercise. A **medical consent form** is **recommended** to participate in the Wellness Center facilities and programs or you can complete a **medical consent waiver form\***.

*\*STAFF IF MEDICAL CONSENT WAIVER FORM IS NEEDED, ATTACH COMPLETED FORM TO APPLICATION*

I do not wish to fill out this form, although I have read and understand the Pre-Participation Screening Questionnaire. I understand that I must complete a **Pre-Participation Screening Questionnaire waiver form\***.

*\*STAFF IF PRE-PARTICIPATION QUESTIONNAIRE WAIVER FORM IS NEEDED, ATTACH COMPLETED FORM TO APPLICATION*

I acknowledge that I have read and understand the Pre-Participation Screening Questionnaire. I assume full responsibility for my health, medical condition and any risks associated with physical activity. It is my responsibility to seek appropriate medical consultation prior to use of the Wellness Center facilities and programs and to notify the Wellness Center of any changes in my health status.

Signature of participant (or parent/guardian if participant is under 18 years of age)

Date

## Informed Consent to Exercise and Release of Liability

**Participant Name** (please print) \_\_\_\_\_

*PLEASE READ CAREFULLY* - By signing this document you are waiving certain legal rights, including the right to sue.

**I wish to become a member of the FAU Student Wellness Center (the Center) so that I may use the Center's facilities without direct supervision, and participate in programs of my choosing that are offered by the Center.**

### Awareness of Risk

- I acknowledge that the Center does not supervise my use and participation and that there are risks associated with participation in any physical training, exercise, sports, or activity programs.
- I acknowledge that the risks associated with my participation may include the risk of physical injury, illness, loss of life, or property damage.
- I am aware of and I understand the risks associated with my use of the facilities, or participation in a program, including the risk of personal injury, and I freely accept these risks.
- I understand that I am free to withdraw from or reduce my participation in the Center or any programs offered by the Center at any time.
- I acknowledge that facility staff may limit my access to the facilities or programs offered in the event of any misuse of the facilities or misconduct on my part.
- I have received, read and understand the FAU Student Wellness Center Facility Rules, and acknowledge and understand that the Member Handbook is available at the Wellness Center and on the Wellness Center website.
- I have completed an FAU Student Wellness Center Application and I confirm that the answers I have given are correct. I understand the form and any questions I had were answered to my full satisfaction.
- I am not aware of any medical condition that would affect my ability to participate in unsupervised activity or any programs offered by the Center that I choose to participate in.
- If I have any concerns about my medical condition, I will consult with my physician before beginning an exercise program or participating in Center offered programs.
- If the Center requires that I obtain medical clearance as a condition of membership, I agree to consult my physician and obtain written permission from my physician prior to commencement of any exercise at the Center, or participation in any programs offered by the Center.
- I agree that the health data, participation data, or other non-personally identifiable information I provide to the Center may be used for research or statistical purposes.

### Release and Waiver

In consideration of the acceptance of my membership at the Center, I hereby for myself, my heirs, executors, administrators, or any others who may claim on my behalf, **covenant not to sue**, and hereby **waive, release and discharge** the Center, Florida Atlantic University, the Florida Atlantic University Board of Trustees, the State of Florida, and all of their subsidiaries, affiliates, agents, officers and employees, volunteers, and anyone acting for or on their behalf (Releasees), from **any and all claims of any kind** for personal injury, illness, loss of life or property damage of any kind or nature, arising out of or sustained in the course of my use of the Center or participation in any programs offered by the Center, whether caused by my action or negligence or the action or negligence of Releasees or third parties. This Release and Waiver applies to all claims, foreseen or unforeseen, including negligence and breach of statutory or other duty of care.

This document shall be construed pursuant to the laws of the State of Florida.

I am at least 18 years of age. If an FAU student less than 18 years of age, parent/guardian consent is required.

\_\_\_\_\_  
**Signature of participant**

Or parent/guardian if participant is under 18 years of age

\_\_\_\_\_  
Date

\_\_\_\_\_  
*If signed by parent or guardian, print name*

\_\_\_\_\_  
Signature of staff

\_\_\_\_\_  
Date

## Facility Rules

The FAU Davie Campus Student Wellness Center disclaims liability for any use of the facility, equipment, or programs which may result in serious physical injury or other bodily harm.

*There is a Member Handbook with the Wellness Center policies available online.*

1. All members must check-in at the control desk before beginning their workout. Failure to check-in means that the member has not been given clearance to use the facilities.
2. Appropriate wellness attire must be worn at all times. Swim suits, jeans, and “cut-offs” are not permitted in the Center exercise area. All members are required to wear shirts and closed-toed shoes at all times.
3. Members must bring a hand towel to the center to wipe down the equipment after use or use the Gym Wipes provided, if necessary.
4. Smoking is not permitted in the Center.
5. Absolutely no food or beverages, *except for water bottles*, are permitted in the Center.
6. Television and radio station selection may be changed by member request, at the discretion of the staff.
7. Removal of any equipment from the Center or opening fire doors may result in immediate suspension from the facility and disciplinary action by the University.
8. Lockers and locks are available daily to the members at no cost. Upon completion of use, the member must return the key to the staff when leaving the Center. If the key or lock is lost or damaged, members will be required to pay the cost of the lock and key. The Student Wellness Center is not responsible for lost, stolen, or damaged items.
9. In the event of an air conditioning malfunction, the Wellness Center will close if temperatures reach 80 degrees Fahrenheit or more.

Initials: \_\_\_\_\_

Staff:	Showed photo ID: Y N	Used Gym: Y N or MCR ( <i>Medical Consent Required-not permitted to participate</i> )
Director:	Enrolled: Y N Semester: S R F	Checked: _____
Input:	Name in HC: _____	Input to HC: _____