Lose Dat® ***WEIGHT LOSS/BODY COMPOSITION*** Challenge

is a **10-week program** designed to educate all participants on how to lead a healthier lifestyle in every facet of life. This program is designed for men and women of all shapes and sizes looking to make a measurable, physical change in their overall appearance. It will allow you the opportunity for the best results-oriented workout you've ever experienced structured in a fun team environment.

Choose a team that fits your personal schedule. The workout schedule includes 20+ trainer-led team workout sessions with your small group (2 days/week) and various group exercise / specialty classes / educational and nutrition seminars plus fun fitness events with the other groups to promote comradery and friendly competition – over 42 hours of organized trainer-led sessions geared to help you lose fat and gain strength!

Weigh Ins are every other week on the *InBody570* professional, medical-grade scale. Individual (optional) and team leaderboards posted throughout the first 7 weeks. The TEAM competition is prized on **% of weight loss from team members averaged together**, plus best Body Composition improvement from every team acknowledged on the runway at the Finale Party!

September 5 – November 10, 2017

Registration Fee	**$75**
Program Fee through Aug. 18	**$699** *(non-members $150 more)*
Late Program Fee after Aug. 18	**$750** *(non-members $150 more)*

Important Dates*:

Kick Off Orientation	Sunday, August 27 (5pm – 7pm)
Initial Weigh Ins	Tuesday/Wednesday, September 5/6
Final Weigh Out	Thursday/Friday, November 9/10
Finale Party Runway/Awards	Friday, November 17

**these dates are subject to change*

2017 Lose Dat® Team Challenge

10-week program: September 5 – November 10, 2017

Member Name_____ **Date** _____

Franco's Acct. # _____ **Phone #**_____

E-mail _____ **Age** _____

PREFERRED WORKOUT TIME FRAME

- ☐ **5:00am – 7:30am** (childcare NOT available)
- ☐ **7:30am – 10:00am** (childcare available after 7:30am)
- ☐ **10:00am – 12:00pm**
- ☐ **4:00pm – 6:30pm**
- ☐ **6:30pm – 8:30pm** (childcare available until 8pm M-Th, 7pm Fri)

PREFERRED TEAM OR TRAINER

Do you have a preferred Trainer?

1st choice_____

2nd choice_____

3rd choice_____

Program T-Shirt (you will receive one free shirt if registered by Aug. 21, additional shirts are $20)
Choose ONE: ____**crew neck** or ___**ladies V-neck**
Ladies V-neck shirts run small. Sample shirts are at the Program Registration Desk.

☐ **S** ☐ **M** ☐ **L** ☐ **XL** ☐ **2XL** ☐ **3XL** ☐ **4XL** ___**# additional shirts ($20 each)**

PROGRAM SELECTION & PAYMENT

NO REFUNDS ISSUED ONCE THE PROGRAM BEGINS on September 5 _____ *Initial here*
Registration is not complete until all paperwork is finalized: Health History Questionnaire, Waiver & Image Release & Physician's Release

Registration Fee ____ **$75** *(give us a NEW referral to waive this fee!)*
Program Fee *(up to Aug 18)* ____ **$699** ___ **$849 non-members**
Late Program Fee *(after Aug 18)* ____ **$750** ___ **$899 non-members**
Upgrade Unlimited Boxing/CrossFit classes ____ **$50/3 months** *(if not a member of Franco's CrossFit)*
Upgrade Unlimited Zone 30 classes ____ **$49/month**

Payment Selection:

- ☐ Charge my membership account in full $_____
- ☐ Charge my account & spread equal payments through Nov 2017
- ☐ Other: Payment must be arranged before you will be placed on a team by contacting the business office at 985-792-0205

Office Use Only *Intl's*_____
___$75 Enrollment Fee
___$____Lose Dat Program
___ Check # ___Cash
___ C.C. _____
or _____ monthly payments of $_____
on account #_____

The non-member fee is a discounted temporary membership with limited access to the facility during team training times only. If non-member would prefer full unlimited access please see a membership rep for options.

$75 registration fee waived for referring a NEW Lose Dat member, then receive $35 off each NEW LD participant your refer after that! The more you refer the more you save!

LOSE DAT® PROGRAM RELEASE OF LIABILITY

I _____ hereby accept all risks associated with my participation in Franco's Lose Dat Team® Weight Loss Challenge Program and release and forever discharge the **Franco's, its employees - including its personal trainers ("TRAINER"), Franco's, and any other officers, agent or volunteers of Franco's ("**RELEASEES") from any and all responsibilities or liability from injuries or damages resulting from or connected with my participation in any of the exercise programs whether arising from the negligence of the RELEASEES or otherwise.

1. I acknowledge and fully understand that I will be engaging in training activities that potentially involve the risk of serious injury, permanent disability or death. Other possible risks may include social and economic losses which might result not only from the RELEASEES own actions, inactions, or negligence, but the actions, inactions, or negligence of others, the condition of the premises or any equipment. Further, that there may be other risks not known or not reasonably foreseeable at this time. I hereby assume full responsibility for all the foregoing risks, known and unknown, and accept responsibility for the damages following any injury, permanent disability, or death.
2. I further acknowledge and understand that Franco's, **its personal trainers and other employees are not licensed medical professional or physicians** and that any information or guidelines provided through the Lose Dat® program, its personal trainers or other employees carries no warranty of any kind, expressed or implied, including, but not limited to, warranties regarding safety or suitability for a particular purpose.
3. Franco's/Lose Dat/Ultra Fit and its employees will implement the most effective principals to help the participant achieve his or her goals within the TRAINER'S *scope of practice*, but cannot guarantee that its products or workouts will be safe, effective or suitable for everyone. For that reason, all services, programs, techniques and materials embodied in such services, are offered without warranties or guarantees of any kind, expressed or implied, and the TRAINER, Franco's and its employees disclaim any liability, loss or damages that may result.
4. **I understand that a physician's approval is highly recommended prior to participating in this program** and have either obtained a signed approval from my physician or have signed the *Physicians Release Form* if I meet one or more of the following criteria: 1) am male age 45 or older, 2) am female age 55 or older, 3) answered "yes" to one or more questions on the *Health History Questionnaire above.*
5. I also acknowledge that some exercise programs might be held outside of Franco's, and hereby accept all risk associated with all offsite exercise programs.
6. I have read this document in its entirety and agree to adhere to all its precepts, as well as all other terms and conditions of Franco's Lose Dat Program. I understand the risks and benefits of the program and any questions that I may have had have been answered to my satisfaction. Upon participation, I do hereby discharge, release and hold harmless the TRAINER, Franco's and its employees from any and all liability for damage claims or losses of any kind or character whatsoever resulting from any injury or condition I may suffer, or resulting from my participation except if such damage(s) or injury(s) is primarily the direct result of gross negligence or misconduct of the RELEASEES and not caused in part by my own negligence.

IMAGE RELEASE Franco's Athletic Club, its members and its employees request and hereunder signed agrees to grant all rights to use my name, photo, voice, appearance, and performance to record on or transfer to video tape, film, slides, photographs, audio tape and or other media now known or later developed to be used for broadcast, exhibit, market, sale, or to be otherwise distributed. I (the signee) hereby release Franco's, its members and its employees or vendors from responsibility for any personal injury suffered by me during production.

BY SIGNING THIS AGREEMENT, I CERTIFY THAT I HAVE READ THIS DOCUMENT AND I FULLY UNDERSTAND ITS CONTENT. I AM AWARE THAT THIS IS VOLUNTARY EVENT AND I AM AGREEING TO THE PARTICIPANT AGREEMENT AND RELEASE OF LIABILITY.

_____ _____ _____

Participant's Signature Date Participant's Name *(Please print legibly)*

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Requested Trainer or Team: _____

Birth Date: _____/_____/_____ Age _____ Gender: M F

Height: _____ Weight: _____lbs. BMI: _____

Emergency Contact:_____ Phone:_____

Personal Physician:_____ Phone:_____

Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. To help determine if you should consult with your doctor before starting Lose Dat® Team Weight Loss Challenge at Franco's Athletic Club, please read the following questions carefully and answer each one honestly. All information will be kept confidential in accordance with the Privacy Act of 1974. This questionnaire is in accordance with the ACSM guidelines for risk stratification. Please check YES or NO:

Cardiovascular Health History

YES	NO	
☐	☐	Have you ever had a definite or suspected heart attack or stroke?
☐	☐	Have you ever had coronary bypass surgery or any other type of heart surgery?
☐	☐	Do you have any cardiovascular or pulmonary disease(s) other than asthma, allergies, or mitral valve prolapse?
☐	☐	Do you have a history of: diabetes, thyroid, kidney or liver disease?
☐	☐	Have you ever been told by a health professional that you have an abnormal resting or exercise electrocardiogram (EKG)?

If you answered yes to any of the above please briefly describe/explain:

_____

_____

_____

_____

_____

*If you answered "YES" to any of the Cardiovascular Health History Questions above you are required to have a Physician Release Form (see attached) signed and turned in before engaging in this exercise program.

Cardiovascular Disease Signs and Symptoms

Do you currently or have you previously displayed any of the following:

YES	No	Unsure	
☐	☐	☐	Pain or discomfort in the chest or surrounding areas when engaged in physical activity?
☐	☐	☐	Shortness of breath at rest or mild exertion and/or unusual fatigue with usual activities?
☐	☐	☐	Dizziness or fainting?
☐	☐	☐	Difficulty breathing while sleeping and/or lying down?
☐	☐	☐	Recurrent swelling of the ankles not related to an injury?
☐	☐	☐	Recurrent heart palpitations or racing heart rate?
☐	☐	☐	Pain in muscles that cause you to stop physical activity?
☐	☐	☐	Known heart murmur?

If you answered yes to any of the above please briefly describe/explain:

_____

☐

*If you answered "YES" to any of the Cardiovascular Disease Signs and Symptoms Questions above you are considered high risk and are **required to have a Physician Release Form** (see Physician Release Form) signed and turned in before engaging in this exercise program. **You can waive your obligation to the required Physician Clearance by both initialing in the box to the left.**

Cardiovascular Risk Factors

YES	No	Unsure	
☐	☐	☐	**Age:** Are you a Male over 45 or Female over 55 years of age
☐	☐	☐	F**amily History** of cardiac events for first-degree blood relative of males under 55 and females under the age of 65
☐	☐	☐	**Tobacco Use:** Currently Smoke or quit smoking no more than 6 months from today
☐	☐	☐	**Obesity:** Body Mass Index (BMI) ≥ 30 or waist girth >102cm (40 inches) for men and > 88 cm (35 inches) for women
☐	☐	☐	**Hypertension:** Systolic blood pressure ≥ 140 mmHg and/or diastolic ≥ 90 mm Hg or on hypertensive medications
☐	☐	☐	**Dyslipidemia:** LDL cholesterol ≥ 130; HDL <40; Total Cholesterol ≥ 200
☐	☐	☐	**Diabetes:** Have been diagnosed with Prediabetes or diabetes mellitus (If Fasting Glucose is unknown this Becomes a positive risk factor in the presence of obesity, sedentary lifestyle and/or hypertension)

☐

*If you answered "YES" to **two or more** of the above Cardiovascular Risk Factors you are considered to be high risk for exercise and we recommend consulting a physician and completing a Physician Release Form prior to engaging in this exercise program. **You can waive your obligation to the Physician Clearance by initialing in the box provided to the left.**

Physiological and Anatomical Concerns

YES	No	Unsure	
☐	☐	☐	Are you pregnant or is it likely you could be pregnant?
☐	☐	☐	Have you had any surgery or been diagnosed with any disease in the past 90 days?
☐	☐	☐	Are you currently under any treatment for blood clots?
☐	☐	☐	Are you currently taking any prescription medications?
☐	☐	☐	Do you have any muscle, bone or joint issue that may be aggravated with exercise?
☐	☐	☐	Do you have any neck or back problems?
☐	☐	☐	Have you been told by a physician that you should not exercise?
☐	☐	☐	Are you currently being treated for any other medical condition that may hinder your ability to exercise?
☐	☐	☐	During the past 6 months have you had any unexplained weight loss or gain (greater than 10 lbs)?

If you answered yes to any of the above please briefly describe/explain:

_____

_____

_____

_____

FOR INTERNAL USE ONLY

Check and list the identified AHA/ACSM coronary risks:

_____ Existing Cardiovascular Disease: _____

_____ Signs or Symptoms of Cardiovascular Disease: _____

_____ Major Risk Factor(s): _____

Risk Stratification	Factors
_____ Apparently Healthy	≤ 1 Risk Factor (No Medical Clearance Required)
_____ High Risk, without Signs or Symptoms	≥ 2 Risk Factors (Physician Release Recommended)
_____ High Risk, with Signs/Symptoms or known disease	Physician Release Required
_____ Pregnant	Physician Release Required

*All clients needing medical clearance must have a signed Physician Release Form prior to engaging in this exercise program.

FITNESS AND LIFESTYLE QUESTIONNAIRE

Describe your current physical activity or exercise program

Type: _____

Frequency: _____ days per week Duration: _____ minutes per workout

Intensity: *LOW* *MODERATE* *HIGH*

What are your specific "FITNESS" goals?

_____ Muscular Strength _____ Weight Loss _____ Reduce Body Fat

_____ Muscular Endurance _____ Injury Rehabilitation _____ Disease Reversal/Prevention

_____ Muscular Tone _____ Flexibility _____ Cardiovascular Fitness

_____Other: _____

What are your specific "WELLNESS" goals?

_____ Control/Reduce Stress _____ Improve Nutritional Habits _____ Stop Smoking

_____ Control Blood Pressure _____ Improve Productivity _____ Pain Management

_____ Control Cholesterol _____ Achieve a Balanced Lifestyle

_____ Feel Better Physically, Mentally, Spiritually _____ Gain Education in the areas of Wellness

_____ Other: _____

What is motivating you to participate in this program?

_____ Support System _____ Medical Reasons

_____ Want/Need a Challenge _____ I'm hooked (Alumni)

_____ Keeps me focused/disciplined _____ See above ☺!

_____ Need direction _____ Other: _____

How did you hear about this program?

_____I participated in Lose Dat before _____Word of Mouth / referred by another member

_____Newspaper / Magazine _____Advertisements /Banner / TV in the club

_____Website / Facebook _____Other: _____

TELL US YOUR STORY *(YOUR TESTIMONIAL)*

We take the "before" testimonial explaining WHY you are choosing to do this program and what your expectations are. Then we will need an "after" testimonial. Email your testimonial to jhudson@myfrancos.com

franco's

Physician Release Form

Your patient, _____ wishes to start a personalized exercise program **September 5 – November 10, 2017.** As a participant in this program, your patient will be instructed in proper exercise techniques working one on one or with a group with a personal trainer.

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 list and explain:

_____
_____
_____

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

_____
_____
_____

My patient, _____, has my approval to begin an exercise program with the recommendations or restrictions stated above.

Physician Name: _____

Physician Practice: _____

Physician's Phone: _____

Physician's Address: _____

Physician Signature:_____ **Date**: _____