



# ULTRA FIT REGISTRATION

September 4 – November 11, 2018 (10 weeks)

Member Name \_\_\_\_\_

Franco's Member Acct. # \_\_\_\_\_ Phone # \_\_\_\_\_

E-mail \_\_\_\_\_

*\*Email is mandatory as that is how you will receive your weekly schedule, communication and leaderboards  
 "Like" Franco's UltraFit Challenge on FB to stay updated on latest news, additions, changes, tips and news!*

## TEAM SELECTION

___ Lisa	5am	M/W	___ Courtney	11:15am	M/W
___ Fernanda	5am	T/Th	___ Courtney	12pm	T/Th
___ Courtney	6:15am	M/Th	___ Lisa	6pm	T/Th
___ Tanya (@CF)	6:30am	M/W	___ Rachel	6pm	M/W
___ Lisa	8:30am	M/W	___ Chris	7pm	T/Th
___ Kylynn	9:30am	M/W	___ Holden	7pm	M/W

**T-Shirt Size** (if registered by Aug. 20 you will receive one free shirt, after August 20 and additional shirts are \$20)

Choose ONE: \_\_\_ crew neck or \_\_\_ ladies tank

S  M  L  XL  2XL \_\_\_ # additional shirts (\$20 each)

## PROGRAM SELECTION & PAYMENT

**NO REFUNDS ISSUED ONCE THE PROGRAM BEGINS without a doctor's excuse \_\_\_\_\_ Initial here**

Check the divisions you would like to participate in:

- Body Composition Challenge** (Male/Female Division)
- Competitive Participation (additional \$75 registration fee)** includes all training sessions/specialty classes, Physical Challenges on Fridays (Male/Female Division) plus the Team Challenge on Nov. 11
- Non- Competitive Participation** includes Group Training Sessions/Friday Specialty Classes but no Friday Challenges or Final Team Challenge (although you can attend to watch!)

**Early Bird Program Fee** (up to Aug 20) \_\_\_\_\_ **\$469** \_\_\_\_\_ \$619 non-members\*

*Early Bird Registration includes FREE 10-week CrossFit/Boxing membership*

**Program Fee** (after Aug 20) \_\_\_\_\_ **\$499** \_\_\_\_\_ \$649 non-members\*

**Competitive Division** \_\_\_\_\_ **\$75**

Credit Card  Check # \_\_\_\_\_  Cash \$ \_\_\_\_\_  Member Acct Charge

*\*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.*



# ULTRA FIT PROGRAM RELEASE OF LIABILITY

I \_\_\_\_\_ hereby accept all risks associated with my participation in Franco's Ultra Fit 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 dieticians or physicians** and that any information or guidelines provided through the Ultra Fit 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 Ultra Fit 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.

Health History Questionnaire, Waiver & Image Release & Physician's Release

I have read this agreement and I understand what I am signing:

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Signature

Date

# 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:

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\*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
- Family 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)  $\geq 30$  or waist girth  $>102\text{cm}$  (40 inches) for men and  $> 88\text{ cm}$  (35 inches) for women
- Hypertension:** Systolic blood pressure  $\geq 140\text{ mmHg}$  and/or diastolic  $\geq 90\text{ mm Hg}$  or on hypertensive medications
- Dyslipidemia:** LDL cholesterol  $\geq 130$ ; HDL  $<40$ ; Total Cholesterol  $\geq 200$
- 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:

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### 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 did Ultra Fit before                      \_\_\_\_\_ Word of Mouth / referred by another member  
\_\_\_\_\_ Newspaper / Magazine                      \_\_\_\_\_ Advertisements /Banner / TV in the club  
\_\_\_\_\_ Website / Facebook                      \_\_\_\_\_ Other: \_\_\_\_\_



## Physician Release Form

Your patient, \_\_\_\_\_ wishes to start a personalized exercise program **September 4 – November 11, 2018**. 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:

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

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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: \_\_\_\_\_