Dear Prospective Faculty & Staff Fitness Program Member:

We are pleased that you are interested in the Faculty & Staff Fitness Program. The program is designed to help you safely begin a regular exercise program and stick with it.

To become a member:

1. Complete and return all forms to:

Emily R. Martini, MS
Program Manager-Faculty Staff and Fitness Program
Department of Human Sciences/Kinesiology
The Ohio State University
A52 PAES Building
305 Annie and John Glenn Avenue
Columbus, OH 43210-1224
Telephone: (614) 292-2255
Facsimile: (614) 688-3432
E-mail: martini.36@osu.edu

2. Emily Martini will email you to schedule a fitness evaluation which includes an exercise stress test, flexibility and strength measures, and body composition. You are eligible for an evaluation every year.
3. Please print and read the pre-test instructions which are available on the website:
   http://fsfp.ehe.osu.edu
4. The evaluation results and exercise recommendations will be explained by your session leader during your exercise appointment.

Times listed are those expected, however scheduling requirements or facility availability occasionally require time changes.

Two payment plans are available for those wishing to be regular members.

Regular Membership

If paying yearly:

Initial fitness evaluation one full year of participation: If paying 3 months at a time:	$250.00
Initial fitness evaluation and 3 months participation: Each subsequent 3 months of participation:	$140.00 $120.00
Payroll deduction is also available **(One year commitment required. NO early terminations or refunds**	**$21.84/month**

Bring payment on the day of your scheduled fitness evaluation. Checks made payable to OSU, money orders, and cashier checks are the only accepted forms of payment. Spouses and domestic partners of faculty and staff are also eligible for the same benefits in this program. If you have any further questions, please feel free to email or call Emily. We look forward to your participation in the program in the near future.

Thanks and happy exercising!

PROGRAM POLICIES

Privacy

The Faculty & Staff Fitness Program (FSFP) recognizes the importance of protecting the privacy of information provided by our members. When applying for membership, individuals must provide and periodically update contact information, medical history, informed consent, and physician's consent. Because we adhere to guidelines set by the American College of Sports Medicine (ACSM), all components of the application are necessary prior to joining FSFP. The services we provide include comprehensive fitness testing, exercise prescription, and ongoing exercise counseling. These things cannot be done safely and effectively without first obtaining a health history and medical clearance. The information members provide is only used within FSFP and is never shared with other medical or insurance organizations. It is kept strictly confidential and is vital to providing our members with the most pertinent health and exercise advice available.

Doctor's Clearance and Permission to Fax Results

Any potential member must submit the signed doctor's consent included in the application. Due to the nature of our exercise physiology program, we adhere to the guidelines and recommendations of the ACSM. The ACSM recommends getting doctor's consent before allowing people to participate in a new exercise program. It is required for all participants. In addition, we require permission to fax any pertinent medical results, including but not limited to exercise blood pressures and heart rates, to the member's physician of choice. It is especially important that a physician read the electrocardiograms (ECGs) taken from the stress test. Any member that does not consent to fax medical results will not be granted entry into FSFP.

Stress Test

Any potential member that wishes to join FSFP must undergo at least a submaximal stress test before being granted entry into the program. Thereafter, this test is optional unless membership lapses for more than 1 year. The test is required to ensure that the potential member has no exercise ECG abnormalities. The FSFP member must consent to faxing the results from the stress test and any other important medical data to his/her doctor of choice. Any member that does not consent to fax medical results will not be granted entry into FSFP.

Use of RPAC

FSFP members have access to the Recreation and Physical Activity Center (RPAC) locker rooms 30 minutes before, any time during, and 30 minutes after any scheduled FSFP session. FSFP members have access to the RPAC class pool only for FSFP scheduled aquatic classes including water aerobics. Any other use of the RPAC is strictly prohibited and will result in the member being charged for his/her illegal usage. In addition, his/her membership to FSFP will be forfeited without reimbursement. Faculty and staff may access the RPAC during acceptable times via BuckID. For spouses or domestic partners that do not have BuckIDs, an RPAC pass can be made at the Welcome Center.

THE OHIO STATE UNIVERSITY
COLLEGE OF
EDUCATION AND HUMAN ECOLOGY

Medical History Form

Date: _____ Date of Birth:_____Height:_____ Weight:_____ _

Name: _____ Address: _____

City: _____State: _____ Zip:_____ Phone: _____

BuckID: _____ Email:_____

Emergency Contact	Relationship to Client	Emergency Contact Phone

Do you have, or have you ever had, any of the following High Risk Events? (Please mark Yes or No):

	Yes	No
Heart Attack		
Any Heart Disease/Condition		
Any Heart-related Surgery		
Chest Discomfort/Palpitations		
Dizziness/Unconsciousness		
Shortness of Breath		
Uncontrolled Blood Pressure		

Please answer the following if you have circled yes to any of the High Risk Events:

Procedures: _____Date: _____

Physician :_ _____Last Visit: _____

Do you have any of these Moderate Risk Conditions? (Please mark Yes or No):

	Yes	No		Yes	No
High Blood Pressure—controlled or treated			Blood relative heart attack/surgery before 55?		
High Cholesterol			Any surgeries in the past 6 months?		
Diabetes or Pre-Diabetes			Any pain rated higher than 6/10? (10 is worse)		
Asthma/Lung Disease?			Physician has given activity restrictions?		
Do you currently smoke?			Have you ever been a smoker in the past?		

Have you ever had the following? (Please mark Yes or No):

	Yes	No		Yes	No
Cancer			Allergies		
Seizures			Fibromyalgia		
Mental Health Problems			Concussion/Unconsciousness		
Anemia			Hernia		
Thyroid Disorder			Osteopenia/Osteoporosis		
Currently Pregnant			Vertigo		

Please List any Medications, Vitamins or Supplements you are currently taking:

Drug/Vitamin Name	Dosage	Reason for Medication

Please Indicate if you have ever had any of the following:

Head/Neck	Yes	No
Pinched Nerve		
Frequent Headaches		
Migraines		
Fracture		
Sprain/Strain		
Arthritis		
Disc Problems		
Surgery:_____		
Other:_____		
Shoulder	Yes	No
Fracture		
Dislocation		
Sprain/Strain		
Arthritis		
Rotator Cuff		
Frozen Shoulder		
Shoulder Impingement		
Surgery: _____		
Other:_____		

Arm/Hand	Yes	No
Fracture		
Sprain		
Arthritis		
Surgery:_____		
Other:_____		
Chest/Abdominal	Yes	No
Fractured Rib		
Hernia		
C-Section		
Other:_____		
Back	Yes	No
Fracture		
Arthritis		
Bulge/Herniated Disc		
Pinched Nerve		
Surgery: _____		
Other: _____		

Hip	Yes	No
Fracture		
Dislocation		
Tendonitis		
Arthritis		
Replacement		
Surgery:_____		
Other:_____		
Upper Leg (Quad/HS)	Yes	No
Sprain/Strain		
Surgery:_____		
Other:_____		
Lower Leg (knee/ankle/ foot)	Yes	No
Fracture		
Arthritis		
Ligament Damage		
Sprain/Strain		
Plantar Fasciitis		
Surgery:_____		
Other:_____		

Fitness and Wellness Needs Assessment

Are you interested in the following services? Please mark your response in the appropriate column

	Yes	No
Nutritional Services		
Wellness Coaching		

Please answer the following questions:

Please indicate your exercise experience: (mark one)

Beginner ☐ *Intermediate* ☐ *Advanced* ☐

What strength training activities interest you? (mark all that apply)

Weight Machines ☐ *Dumbbells* ☐ *Cable Exercises* ☐ *Band Exercises* ☐ *Plate Loaded Equipment* ☐

What cardiovascular activities interest you? (mark all that apply)

Walking ☐ *Elliptical* ☐ *Bikes* ☐ *Swimming* ☐ *Running* ☐ Group Exercise Classes ☐

What type of exercise program are you interested in developing? (please mark one)

All Strength Training ☐ *Strength and Cardiovascular mix* ☐ *All Cardiovascular Activity* ☐

Current Health Status: **Please mark yes or no**	**Yes**	**No**
Are you exercising a minimum of 3 times per week for at least 30 min at a time? If yes, please specify the type of exercise._____	☐	☐
Do you feel your current or previous exercise routines are/were successful?	☐	☐
Do you feel your stress level you experience on a daily basis is higher than it should be?	☐	☐

Fitness Expectations/Goals:

1. _____
2. _____
3. _____

How many days per week do you anticipate exercising at our facility?: _____

How long do you want to spend exercising at our facility (minutes)?: _____

What are your concerns with beginning a exercise routine? _____

_____

Present this letter to your physician with the attached clearance form.

Dear Dr. _____,

Your patient, _____, has applied for admittance to the Faculty & Staff Fitness Program, Department of Human Sciences/Kinesiology at The Ohio State University.

This program involves a symptom limited graded exercise test for the evaluation of each participant's initial fitness level. This test, performed on a treadmill, is administered by staff and graduate students in exercise physiology. Also included is measurement of upper and lower body strength, flexibility, and body composition. The participant's exercise prescription, based on these results, may include any combination of the following: walking, jogging, swimming or strength training of specific muscle groups. Participants are encouraged to attend the supervised exercise sessions.

By completing the enclosed form, we acknowledge that you are not assuming any responsibility for our administration of this program. However, if you know of any medical or other reasons why participation in this fitness program would not be in the best interest of this individual, we would appreciate your indication on the enclosed Report of the Personal Physician form. Thank you for your help.

Sincerely,

Emily R. Martini, MS
Program Manager-Faculty Staff and Fitness Program
Department of Human Sciences/Kinesiology
The Ohio State University
A52 PAES Building
305 Annie and John Glenn Ave
Columbus, OH 43210-1224

Telephone: (614) 292-2255
Facsimile: (614) 688-3432
E-mail: martini.36@osu.edu

Enclosure

The Ohio State University

Faculty & Staff Fitness Program Physician's Consent

REPORT OF PERSONAL PHYSICIAN

Patient Name: _____

Please check the most appropriate one:

☐ 1. I know of no reason why he/she may not participate.

☐ 2. I believe he/she could participate, but urge caution because of:

_____

_____

☐ 3. I recommend he/she not participate due to:

_____

_____

Physician's Signature _____

Physician's Name (Print) _____

Physician's Address _____

_____

The below signature is required of all individuals wishing to join FSFP.

I hereby authorize the release of my medical records to the physician named above.

Patient Signature: _____ Date: _____

(Revised 2/16)

THE OHIO STATE UNIVERSITY

Faculty & Staff Fitness Program

In order to determine my personal fitness, I the undersigned, voluntarily request the right to participate in the Faculty & Staff Fitness Program being offered by the Department of Human Sciences of The Ohio State University, commencing _____ (month), 20_____(year).

As part of said program, I understand and agree to the following:

1. An evaluation will be conducted to determine my cardiorespiratory fitness, strength, flexibility and body composition. Complications during exercise tests have been few. If the individual exercising is not tolerating it well, this usually becomes apparent and the exercise is stopped. Mild light-headedness and even fainting may occur. However, they are uncommon and disappear quickly after lying down. Other risks of injury while using equipment involved in testing are possible, but rare.
2. The most demanding test will be the cardiorespiratory evaluation, which typically consists of walking or running on a treadmill to examine my heart rate response to graded exercise.
3. The results of said tests are not to be construed as diagnostic in any sense, but rather are to be used only to establish an exercise program with certain guidelines. This program will be designed to improve my physical fitness.
4. The results of such evaluation do not constitute a clearance of any kind but are only to be considered in connection with said program.
5. My private physician and/or consultant physicians involved in the program are hereby authorized to discuss with those responsible for the exercise program any aspect of my medical history and/or examination which may be appropriate or necessary for my evaluation for or participation in the Faculty & Staff Fitness Program.
6. I will need to request written authorization from my personal physician before being allowed to participate in this program.
7. The Faculty & Staff Fitness Program is not a substitute in any way for a physical examination by my physician, and I agree to consult my physician for such examination and for such medical care as I require.
8. This program, and any tests and exercises which are a part of it are all offered on a voluntary basis. I am not obligated to participate and may withdraw at any time.
9. It is possible for injury to occur through this program, and I agree to fully assume that risk.
10. I have carefully read and understand the above information. The program, tests and exercises have also been explained to me, and any questions have been answered to my satisfaction. I wish to participate in the Faculty & Staff Fitness Program.

Name of Family Physician _____

Address of Physician _____

_____

Physician's Phone Number _____ Fax Number _____ (please include if you want ECGs faxed to your doctor)

Signature: _____ Date: _____

(Revised6/17)

RELEASE OF ALL CLAIMS

Faculty & Staff Fitness Program

The Ohio State University (the "University") in support of the educational activities within its Department of Human Sciences (the "Department") is offering a Faculty & Staff Fitness Program, commencing

_____(month), 20_____ (year).

Although I realize that it is possible for injury to occur through this testing and/or exercise program, I agree to the following:

In consideration of being granted the opportunity to participate in the "Faculty & Staff Fitness Program", and to use equipment and receive the help, assistance and advisory services rendered by members of the staff and employees of the University during this program, I release and forever discharge for myself and my heirs, executors, administrators and assigns, The Ohio State University and its officers, agents and employees who arrange, provide, advise or supervise the above program, and/or any testing and exercise activities there under or any other function associated with participation in this program, from all claims, demands, actions, and causes of action for personal injury or any other damages now existing or which may hereafter arise out of or be in any way related to their conduct associated with the activities of the Department.

Signature: _____ Date: _____

(Revised6/16)