



Instructional Programs 2011-2012 Registration Form

Last Name: _____ First Name: _____

Email (*required*): _____

Phone #: _____

Emergency Contact Name: _____ Phone #: _____

Note: All non UMass Lowell Students must be 18+ to participate in CRC Instructional Programs (unless otherwise noted). The CRC does not give out refunds after session has started.

Please check which program you are registering for:

Spring Ballroom Dance (Beginner / Intermediate) <i>circle one</i>	Spring Salsa Dance _____
Spring Hip Hop, Jazz Dance & More _____	Ballroom Community Program _____
Spring Athletic Training Instructional Class _____	
NETA Spring 2-Day Personal Training Certification Class 4/14 – 4/15 _____	
Spring Lifeguard Training & Review 3-Day Class (Includes CPR/AED for Prof. Rescuer) 3/19, 3/21, 3/23 _____	
American Red Cross CPR/AED & First Aid (select which date): 3/31 _____ 4/22 _____	

NOTE: WE DO NOT GIVE REFUNDS AFTER CLASSES HAVE BEGUN!!!

Please check one: ___ Student ___ Non-Student/CRC Member
 ___ Non-Member-*must fill out health history questionnaire on back of form*

I understand that participating in a Campus Recreation program is purely voluntary and that neither the Department of Athletics nor the University of Massachusetts Lowell assumes the responsibility for any injury sustained through my participation. I am aware of the risks inherent in participation in this type of physical activity and agree that it is my responsibility to determine whether or not I am physically fit to participate in this program.

Signature: _____ Date: _____

I **DO NOT** give UMass Lowell permission to use my picture in any marketing materials. (Please Initial) _____

Name _____ Date: _____

Emergency Contact: _____ Phone: _____

UMASS Lowell CRC Health History Questionnaire



Chart A. To the best of your knowledge, do you have any of the following? Please check all that apply.

<input type="checkbox"/> history of heart disease or heart attack	<input type="checkbox"/> heart trouble or transplant	<input type="checkbox"/> vascular disease
<input type="checkbox"/> bypass or angioplasty	<input type="checkbox"/> chronic obstructive pulmonary disease	<input type="checkbox"/> emphysema
<input type="checkbox"/> asthma	<input type="checkbox"/> diabetes	<input type="checkbox"/> epilepsy
<input type="checkbox"/> bronchitis	<input type="checkbox"/> stroke	<input type="checkbox"/> currently pregnant
<input type="checkbox"/> known heart murmur	<input type="checkbox"/> shortness of breath at rest/mild exertion	<input type="checkbox"/> dizziness or fainting
<input type="checkbox"/> heart palpitations	<input type="checkbox"/> claudication	<input type="checkbox"/> rapid heart beat
<input type="checkbox"/> shortness of breath when lying flat or in bed		
<input type="checkbox"/> pain or discomfort in chest or surrounding area		

Chart B. ACSM risk factors for coronary heart disease: Please check all that apply.

Age: Are you male and over the age of 45 OR female and over the age of 55?

Family History: Is there a history of heart attack, coronary revascularization, or sudden death in your immediate relative males (father, brother, son) before age 55 or females (mother, sister daughter) before age 65?

Hypertension: Has your systolic blood pressure been greater than or equal to 140 mmHg or has your diastolic blood pressure been greater than or equal to 90mmHg on at least two separate occasions?

Impaired fasting glucose: Have you had fasting blood glucose of greater than or equal to 110mg/dL on at least two separate occasions?

Obesity: Do you have a BMI (Body Mass Index) of 30kg/m² or more, or a waist girth of greater than 39.4 inches (100cm)?
See chart for BMI.

Hypercholesteremia: Is your total blood cholesterol greater than 200mg/dL, or you LDL greater than 130 mg/dL, or is your HDL below 35 mg/dL, or are you on lipid lowering medication?

Sedentary Lifestyle: Are you currently inactive, i.e. no regular exercise or recreation, and have a sedentary job?

Cigarette Smoker: Are you a current smoker, or have you quit within the previous 6 months?

I have read, understood, and completed this questionnaire. I understand that this questionnaire is used solely for screening purposes to help determine my readiness to participate in physical activity or fitness assessment and that it is not to replace professional medical advice or evaluation.

Signature: _____

Date: _____

Witness: _____

Date: _____

If you answered checked off 1 or more conditions in Chart A OR 2 or more conditions in Chart B, written physician approval **is required** prior to your use of the Campus Recreation Center or participation in our programs. If this is the case, please complete the Medical Information Release form below.

MEDICAL INFORMATION RELEASE

Please provide the following information to expedite the physician approval process. I hereby give my physician permission to release any pertinent medical information from my medical records to the University of Massachusetts at Lowell. I understand that this information will be kept confidential. I am aware that this release will expire within one year of signature & that I may revoke my medical release at any time.

Participant's Signature: _____ Date of Birth: _____ Today's Date: _____

<u>Name of Physician</u>	<u>Address</u>	<u>Phone & Fax Numbers</u>
		(phone): _____
		(fax): _____