



Private Tennis Lesson Registration

Once you are assigned to a Tennis Instructor and are notified by Fitness and Well-Being staff through email, you may proceed with payment. Upon receipt of the Tennis Lesson Registration, individuals will be contacted within 5 business days regarding registration status. Prior to submission of the Tennis Lesson Registration please sign and date the LSU UREC Participation Agreement (see reverse).

Participant Information

Last Name First Name Gender Identification Age

Date of Birth Phone Number E-mail Address

Classification

UREC Student UREC Member Non-Member

Emergency Contact

Last Name First Name Phone Number Relationship

Individual Training Packages and Preferences

Select a Package

	Student	Member	Non- Member
Three Sessions	\$90.00	\$115.00	\$135.00
Five Sessions	\$140.00	\$165.00	\$185.00
Seven Sessions	\$195.00	\$220.00	\$240.00
Ten Sessions	\$280.00	\$305.00	\$325.00

Fitness Goal

Desired Completion Date

Availability

Monday Tuesday

Wednesday Thursday

Friday Saturday

Sunday

Trainer Preference

No Preference

Male Trainer

Female Trainer

Trainer's Name

Medical History

Have you or an immediate family member now or in the past experienced? **

You	Family	You	Family	You	Family
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain while exercising		Tendonitis		Currently pregnant/postpartum	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma		High blood pressure (>140/190)		Cancer	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack		Muscle Injury		Depression	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis		Diabetes mellitus		Osteoporosis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease		Joint Injury		Low back pain	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis		Dizziness/Loss of Consciousness		High Cholesterol (total > 200)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker		Smoking		Nutrition relation disorder	

If you have checked any boxes, please explain:

Please list any medications that you are currently taking:

Participant Agreement

I understand and agree that there is a risk of serious injury to me while utilizing University Recreation facilities, equipment, and programs and recognize every activity has a certain degree of risk, some more than others. By participating, I know and voluntarily assume any and all risk of injuries, regardless of severity, which from time to time may occur as a result of my participation in athletic and other activities through LSU University Recreation. I hereby certify I have adequate health insurance to cover any injury or damage that I may suffer while participating, or alternatively, agree to bear all cost associated with any such injury or damages myself. I further certify that I am in good health and have no mental or physical condition or symptoms that could interfere with my safety or the safety of others while participating in any activity using any equipment or facilities of LSU University Recreation. I understand and agree that I alone am responsible to determine whether I am physically and mentally fit to participate, perform, or utilize the activities, programs, equipment or facilities available at Louisiana State University, and that I am not relying on any advice from LSU University Recreation in this regard. To the extent I have any questions or need any information about my physical or mental condition or limitations, I agree to seek professional advice from a qualified physician. Further, I hereby release and hold harmless the State of Louisiana, the Board of Supervisors of Louisiana State University and Agricultural & Mechanical College, and its respective members, officers, employees, student workers, student interns, volunteers, agents, representatives, institutions, and/or department from any and all liability, claims, damages, costs, expenses, personal injuries illnesses death or loss of personal property resulting, in whole or in part, from m participation in, or use of, an facility, equipment and/or programs of Louisiana State University.

Printed Name of Participant

Signature of Participant

Printed Name of Parent/ Legal Guardian
(If under 18)

Signature of Parent/ Legal Guardian
(If under 18)

Date

**You MUST complete the PAR-Q+ form below prior to to submitting your registration.
Registration forms submitted without completing the PAR-Q+ form are considered
incomplete and may delay processing.**

Option to e-mail or scan printed form to urecfitness@lsu.edu

2021 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
1) Has your doctor ever said that you have a heart condition <input type="checkbox"/> OR high blood pressure <input type="checkbox"/> ?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
3) Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise).	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer NO if you had a problem in the past, but it does not limit your current ability to be physically active. PLEASE LIST CONDITION(S) HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your doctor ever said that you should only do medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered NO to all of the questions above, you are cleared for physical activity.

Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow Global Physical Activity Guidelines for your age (<https://www.who.int/publications/i/item/9789240015128>).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

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FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?

If the above condition(s) is/are present, answer questions 1a-1c If **NO** go to question 2

- 1a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES NO
- 1b. Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)? YES NO
- 1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months? YES NO

2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a-2b If **NO** go to question 3

- 2a. Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck? YES NO
- 2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)? YES NO

3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm

If the above condition(s) is/are present, answer questions 3a-3d If **NO** go to question 4

- 3a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES NO
- 3b. Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction) YES NO
- 3c. Do you have chronic heart failure? YES NO
- 3d. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months? YES NO

4. Do you currently have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b If **NO** go to question 5

- 4a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES NO
- 4b. Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure) YES NO

5. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes

If the above condition(s) is/are present, answer questions 5a-5e If **NO** go to question 6

- 5a. Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies? YES NO
- 5b. Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness. YES NO
- 5c. Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet? YES NO
- 5d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)? YES NO
- 5e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future? YES NO

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6. Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome

If the above condition(s) is/are present, answer questions 6a-6b If **NO** go to question 7

6a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES NO

6b. Do you have Down Syndrome **AND** back problems affecting nerves or muscles? YES NO

7. Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure

If the above condition(s) is/are present, answer questions 7a-7d If **NO** go to question 8

7a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES NO

7b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy? YES NO

7c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week? YES NO

7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? YES NO

8. Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia

If the above condition(s) is/are present, answer questions 8a-8c If **NO** go to question 9

8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES NO

8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? YES NO

8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)? YES NO

9. Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event

If the above condition(s) is/are present, answer questions 9a-9c If **NO** go to question 10

9a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES NO

9b. Do you have any impairment in walking or mobility? YES NO

9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? YES NO

10. Do you have any other medical condition not listed above or do you have two or more medical conditions?

If you have other medical conditions, answer questions 10a-10c If **NO** read the Page 4 recommendations

10a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months? YES NO

10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)? YES NO





10c. Do you currently live with two or more medical conditions? YES NO

**PLEASE LIST YOUR MEDICAL CONDITION(S)
AND ANY RELATED MEDICATIONS HERE:** _____

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

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 **If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:**

-  It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
-  You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
-  As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
-  If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

 **If you answered YES to one or more of the follow-up questions about your medical condition:**

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+** at **www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

 **Delay becoming more active if:**

-  You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
-  You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at **www.eparmedx.com** before becoming more physically active.
-  Your health changes - talk to your doctor or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____

DATE _____

SIGNATURE _____

WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact
www.eparmedx.com
Email: eparmedx@gmail.com

Citation for PAR-Q+

Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

Key References

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(51):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(51):S266-s298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.