Stay Strong, Stay Healthy—**Level 2**

Participant Enrollment

Name: _____

Best phone number: _____ Email: _____

Age and year of birth: _____ Gender: _____

In case of emergency, please call (please list two contacts):

Name: _____

Relation: _____ Phone number: _____

Name: _____

Relation: _____ Phone number: _____

At University of Missouri Extension, we want to make sure we are presenting our programs to a wide range of participants. This information is voluntary and confidential, and will be used to identify our audiences in general.

Race

- ❑ American Indian/ Alaskan Native
- ❑ Asian
- ❑ Black or African-American
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White
- ❑ Two or more races/Other
- ❑ Unknown

Hispanic

- ❑ Yes ❑ No

Veteran status

- ❑ Nonveteran
- ❑ Veteran
  - ❍ Vietnam Veteran
  - ❍ Other

Disabled

- ❑ Yes ❑ No

I need to tell you...

Here's where you can put any pertinent health conditions that you think the instructor needs to know.

--- Below is for instructor use only ---

Program site: _____

County: _____

Start date: _____

Returning participant initial if all responses are the same _____ ***Date*** _____

For instructor use. Valid for one year.

Stay Strong, Stay Healthy—**Level 2**

Voluntary Physician Authorization Form

Patient's Name: _____ Birth Year: _____

❑ Yes, my patient can participate.

❑ Yes, my patient can participate with the following limitations:

❑ No, my patient cannot participate at this time because of his or her medical conditions and health status.

Physician's signature: _____

Print name: _____ Date: _____

Phone number: _____ Fax: _____

This form may be given to the patient or instructor by fax, email or mail to:

Please return this form by: _____

For instructor use. Valid for one year.

Stay Strong, Stay Healthy—**Level 2**

PAR-Q

Physical Activity Readiness Questionnaire

Participant Name: _____

Regular exercise is associated with many health benefits, though any change of activity may increase the risk of injury. Complete this questionnaire as a first step toward increasing the amount of physical activity in your life. Please read each question carefully and answer every question honestly:

YES	NO	
○	○	1. Has a physician ever said you have a heart condition and that you should only perform physical activity recommended by a physician?
○	○	2. Do you feel pain in your chest during physical activity?
○	○	3. In the past month, have you had chest pain at a time when you were not doing physical activity?
○	○	4. Do you ever lose consciousness or do you lose your balance because of dizziness?
○	○	5. Do you have bone or joint problems (back, knee or hip) that may be made worse by a change in your physical activity?
○	○	6. Is a physician currently prescribing medications for your blood pressure or a heart condition?
○	○	7. Are you 69 years of age or older?
○	○	8. Do you know of any other reason why you should not exercise or increase your physical activity?

If you answered "yes" to any of the above questions, we strongly request that your doctor complete a Physician Authorization Form before beginning a Stay Strong, Stay Healthy class. Your instructor can provide the form to you or your physician.

If you honestly answered "no" to all questions, you can be reasonably sure that you can safely and gradually increase your level of physical activity.

Note: This PAR-Q is valid for a maximum of 12 months from the date it is completed. If at any time your medical condition changes, you must complete a new PAR-Q and the previous one becomes invalid.

Participant signature _____ Date _____

Returning participant initial if all responses are the same ____ ***Date*** _____

For instructor use. Valid for one year.

Stay Strong, Stay Healthy—**Level 2**

Voluntary Physician Cover Letter

Physician Name: _____

Hospital/Clinic Affiliation: _____

Phone Number: _____

Fax Number: _____

Date: _____

Dear Dr. _____ :

Your patient, _____ , is interested in participating in the ***Stay Strong, Stay Healthy-Level 2 Program***. This moderate-intensity, progressive exercise program includes strength and balance training and is designed to build on the exercises learned in the first level and continue improving muscle strength, dynamic balance and flexibility. Some exercises in this course incorporate moving safely to and from the floor.

This is an evidence-based exercise program designed especially for midlife and older adults. It was developed and researched by faculty at University of Missouri Extension. _____ is/are implementing the program in _____ . Your patient will be required to provide informed consent prior to participation in this exercise program and is informed of the associated risks.

Please complete and sign the enclosed Physician Authorization Form. If you have any questions or would like to discuss your patient's participation in the program in further detail, please call me at _____.

Sincerely,

Stay Strong, Stay Healthy—**Level 2**

Participant Consent

I have voluntarily enrolled in a program of progressive exercise and understand that I may choose to quit the program at any time. The program is designed to place a gradually increased workload on the heart, lungs, muscles and bones to help improve their function. I understand that participation in such a program may be associated with some risks. These risks may include but are not limited to muscle soreness, fainting, disorders of heart beat, abnormal blood pressure, and in very rare instances, heart attack which could lead to death. To the best of my knowledge I do not have any limiting physical conditions or disability that would preclude an exercise program. Effort will be made to minimize any risks to me by a voluntary pre-exercise assessment and a voluntary medical screening. If my medical status changes during the program, I will inform the program leader and my health care provider to see if it is safe to proceed with the program. That in consideration of my participation in this program, I agree, on behalf of myself, my assigns, executors, and heirs, to release and hold harmless

_____

and the University of Missouri and their trustees, officers, employees, and agents from any and all liability, damage, or claim of any nature whatsoever arising out of my participation. I assume all risks and responsibility for any injury, damage, or any other adverse event that may result from my participation in this program.

Before I begin this program I understand that a pre-exercise assessment is offered and voluntary physician screening consent form may be completed. I understand that each person may react differently to these fitness activities and these reactions cannot be predicted with complete accuracy. I will inform the program leader and/or my health care provider if I experience any unusual symptoms.

I understand that the benefits to me of participating in this program may include increased strength and, as a result, improved health. I understand that this program will be evaluated for future program improvement and results may be published, but that at no time will my individual results be identifiable in such reports.

I understand that if I have any questions about my involvement in the evaluation of this program, I may contact Kelsey Weitzel, Department of Nutrition and Exercise Physiology, MU Extension. Phone: 573-882-2799. Email: muextsssh@missouri.edu

Signature: _____

Printed Name: _____

Date: _____

Returning participant initial if all responses are the same _____ ***Date*** _____

For instructor use. Valid for one year.