



Gimli Fitness Centre Member Application

www.gimli.ca

Name: _____ Birthdate (MM/DD/YY): _____

Address _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Terms and Conditions: (Applicants must read the conditions below)

Please be advise the gym is equipped with 24-hour surveillance for safety, security and hygiene purposes

I certify that I am 18 years of age or older and all facts and information provided above are true and correct.

I understand membership fees (including swipe cards) are non-refundable.

Members 12-17 years of age must have a parent or guardian complete this form.

Members 12-15 years of age must be directly supervised by an adult (18+) at all times while in Fitness Centre.

The supervising adult must have their own membership.

Members are required to wear proper indoor footwear while using the gym. Outdoor shoes are **not** permitted.

All equipment must be returned to racks after sets, including heavy weights.

Equipment must be wiped down after use with the towels and disinfectant provided.

Members must **not** share passes with anyone. Pass sharing will result in your membership being revoked.

Membership holds are possible with six month or one-year membership, for employment purposes or with a doctor's note only.

Members caught letting in any individuals without a valid membership to the Gimli Fitness Centre will have their memberships revoked.

Informed Consent Agreement

I, the undersigned hereby acknowledge that certain risks or injury are inherent to participate in sports and recreational activities. These types of injuries may be minor or serious and may result from one's own actions, or the actions or inactions of others, or a combination of both. I understand that certain rules and regulations are designed for the safety and protection of participants and therefore undertake to abide by these rules and regulations.

I understand that certain activities require a minimum level of fitness and health (physical, mental, emotional) and that each person has different capacity for participating in these activities. I hereby warrant being physically fit to participate and understand that the choice to participate brings with it the assumption of those risks and results, which are part of those activities.

I agree that the Gimli Fitness Centre or its agents or contractors shall not be liable for any injury to my person or loss or damage to personal property arising from, or in any way resulting from my participation in these activities, unless such injury, loss or damage is caused by the sole negligence of the Gimli Fitness Centre or its employees, agents or contractors while acting within the scope of their duties.

I declare that I have read and understand the above Terms & Conditions, and the "Informed Consent Form Agreement" in its entirety and hereby consent to participate acknowledging all of the foregoing.

By signing this application, I acknowledge that I have read and understand the terms laid out in this application and agree to abide by them.

Signature: _____ Date: _____

2024 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 OR high blood pressure <input type="checkbox"/> ?	D	D
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	D	D
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).	D	D
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE: _____	D	D
5) Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE: _____	D	D
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: _____	D	D
7) Has your doctor ever said that you should only do medically supervised physical activity?	D	D

✓ 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. **1**

- 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 **j**

(ii) 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-^{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, diuiness 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 lightness, 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 in 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

Officer for PA114+

Warburton DER, Jamnik VK, Bredin SSO, 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):1-23, 2011.

Co-Editors

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L. Warburton, D.E.R., N. Gledhill, M. Jamnik, V.K., S. Bredin, S.S.O., M. McKenzie, D.C., S. Stone, E.J., Chai, S. Worth, S., and S. Shephard, R.J. Evidence-based risk assessment and recommendations for physical activity clearance. Canadian Journal of Public Health 102(5):333-338, 2011.

L. Chisholm, M. Collins, M.L. Kula, L.L. Davenport, W., and Gruber, N. Physical activity readiness. British Columbia Medical Journal 1975; 17:375-378.

Thomas S, Reading J, and Shephard R.J. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992; 17:4338-345.

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.