



# Request for Fitness Training

**Real Results for Real People ... From Professionals Who Care!**

Thank you for your interest in fitness training at Mount Vernon RECenter. Whether you want to improve health, improve sports-specific performance, or just look and feel good, we have a trainer waiting to develop a fun, innovative program for you. Let us help you:

- Set achievable goals based on your health and fitness level while providing the motivation and encouragement you need to reach them;
- Design a program custom-tailored to meet your individual needs and goals; and
- Measure your progress toward achieving your goals.

**PROGRAMS OFFERED:**

We offer **Individual**, **Small Group** (2-4 participants) and **Specialty** Instruction (Pilates Reformer Machine, Gravity Trainer). A trainer will be assigned to you, and will contact you directly.

**ABOUT OUR TRAINERS:**

All FCPA trainers are certified through nationally recognized certification programs. Our trainers have years of experience in fitness and personal training, and many have formal education in the fields of exercise science, physical education, exercise physiology, or a related field. The Fitness Director will assign a trainer based on availability, and, if necessary, specialty.

**What are you interested in (please check all that apply)?**

**Personal Training (Individual)**

**Small Group Training (2-4 participants)**  
(please write names of other group members below)

**Specialty Training** (Pilates Reformer, Gravity GTS, PT/RD)

**Other Fitness Services**

	Type	Fee	Code
<input type="checkbox"/>	<b>Fitness Evaluation (55-minutes)</b> Body Composition with Calipers <i>Note: this can be included as the first session in a 6-session package.</i>	\$50	FITEVALCAL
<input type="checkbox"/>	<b>Fitness Evaluation (55-minutes)</b> Body Composition with In-Body230	\$55	FITEVAL230
<input type="checkbox"/>	<b>Body Composition Analysis</b> With In-Body230 Print Out	\$15	BODCOMP230
<input type="checkbox"/>	<b>Body Composition Analysis with</b> 30 Minute Consult	\$30	BODCOMP230C

**Preferred Session Days**

**Preferred Times**

**Please take the section here to briefly explain your goals**

**Name (Please Print Legibly)**

**Phone Number**

**Email**

## Fitness Training Fees

**Single Sessions (one visit):**

- Individual 30-min = \$30.00
- Individual 55-min = \$50.00
- Small Group 55-min = \$60.00\*
- Specialty Individual 30-min = \$35.00
- Specialty Individual 55-min = \$60.00
- Specialty Small Group 55-min = \$75.00\*

*\*Fees for small group sessions are split equally between group members. For breakdown of per person prices, see Small Group Training Contract.*

**6 Session Discount Packages (10% discount):**

- Individual 30-min= \$162.00
- Individual 55 min= \$270.00
- Small Group 55 min= \$324.00\*
- Specialty Individual 30 min= \$189.00
- Specialty Individual 55 min= \$324.00
- Specialty Small Group 55 min= \$405.00\*

*\*Fees for small group sessions are split equally between group members. For breakdown of per person prices, see Small Group Training Contract.*

## Mount Vernon RECenter

2017 Belle View Blvd.  
Alexandria, VA 22307  
703-768-3224  
[www.fairfaxcounty.gov/parks](http://www.fairfaxcounty.gov/parks)

Mary Malof  
Fitness Director  
[Mary.malof@fairfaxcounty.gov](mailto:Mary.malof@fairfaxcounty.gov)



The Fairfax County Park Authority is committed to equal access in all programs and services. Special accommodations will be provided upon request. Please call the ADA/Access coordinator at least 10 working days in advance of the date services are needed.

703.324.8563 (Phone) • 703.803.3354 (TTY) • [www.fairfaxcounty.gov/parks/ada.htm](http://www.fairfaxcounty.gov/parks/ada.htm)

V. Feb 2011

## Client Information

First Name	MI	Last Name	Nickname																				
Address																							
City	State	Zip																					
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M	M	-	D	D	-	Y	Y	Y	Y														
Email Address		Height	Weight																				
Emergency Contact Name	Relationship	Primary Phone	Secondary Phone																				

## Short Health History Questionnaire

**Please answer the following questions:**

<i>If you answer "Yes" to one or more of the following questions, you will need a signed medical clearance from your physician before beginning an exercise program with us. Please contact the Fitness Director for more information.</i>	YES	NO
Are you over the age of 65?	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently have pain in your heart and chest?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel faint or have spells of severe dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high blood pressure (either controlled or uncontrolled)?	<input type="checkbox"/>	<input type="checkbox"/>
Has a doctor ever told you that you have a bone or joint problem, such as arthritis, that has been aggravated by exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Has your doctor ever said that you have heart trouble?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a good physical reason, not mentioned here, why you should not follow an activity program even if you wanted to?	<input type="checkbox"/>	<input type="checkbox"/>

**Please select all known health conditions:**

Cardiovascular	Musculoskeletal	Pulmonary	Other
<input type="checkbox"/> Chest Discomfort <input type="checkbox"/> Coronary Bypass <input type="checkbox"/> Current Heart Murmur <input type="checkbox"/> Extra/Skipped/Rapid Heart Beat <input type="checkbox"/> Heart Attack <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Phlebitis or Emboli <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Stroke	<input type="checkbox"/> Ankle Swelling <input type="checkbox"/> Back Problems <input type="checkbox"/> Broken Bones (recent) <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Foot Problems <input type="checkbox"/> Joint Replacement <input type="checkbox"/> Knee Problems <input type="checkbox"/> Limited Joint ROM <input type="checkbox"/> Lupus <input type="checkbox"/> Neck Problems <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Shoulder Problems <input type="checkbox"/> Swollen, Sore or Painful Joint(s)	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Emphysema <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pulmonary Edema	<input type="checkbox"/> Anemia <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy or Seizures <input type="checkbox"/> Parkinson's <input type="checkbox"/> Previous Heat Stroke <input type="checkbox"/> Pregnancy <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Vision Impairment/Cataracts <input type="checkbox"/> Surgeries: _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____



# PHYSICIAN'S MEDICAL CLEARANCE

Please complete and return to: Mary Malof, Fitness Director - Mount Vernon RECenter.

**FAX # 703-765-0467 / Phone # 703-768-3224**

Thank you for your assistance. Please call if you have any questions.

Member's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize my health care provider to disclose individually identifiable health information to the above identified Fitness Director for the purpose of participating in Fairfax County Park Authority (FCPA) exercise programs. I have the right to revoke (or cancel) this authorization, but my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health information already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. Health information disclosed under this authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of my health care provider.

This authorization expires upon termination from facility.

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*

Dear Dr. \_\_\_\_\_,

The above named patient has expressed an interest in beginning an exercise program at a FCPA Recreation center. Participation in the program will include involvement in a personalized exercise routine. Based on the responses given on a health history questionnaire, we are requesting medical clearance.

Please indicate any medication(s) currently taken by this patient/client and indicate any physiological effects the medication (s) may have:

<b>Medication</b>	<b>Effect(s)</b>
_____	_____
_____	_____
_____	_____

### Physician's Recommendation:

\_\_\_\_ Patient **may** participate in a sub-maximal exercise program.

\_\_\_\_ Patient **may not** participate.

### Physician's Contraindications and/or Exercise Limitations:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
E-Mail Address

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Fax Number



# EXERCISE PROGRAM INFORMED CONSENT

I, \_\_\_\_\_, acknowledge that entering into an exercise program is designed to improve my personal fitness. I understand that in undertaking this exercise program, made available through the Fairfax County Park Authority (hereafter known as "FCPA"), some risk may be involved, and I fully assume that risk.

I understand and am aware that strength and aerobic exercise, including use of equipment, are potentially hazardous activities. I further understand that fitness activities may involve a risk of musculoskeletal injury and even death, and I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

I do hereby declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity, or illness that would prevent my safe participation or use of equipment except as hereinafter stated.

I understand that any fitness evaluation performed by FCPA personnel is not a substitute in any way for a diagnostic evaluation by my physician and is solely used as a means to establish baseline fitness parameters in order to develop my exercise program. I have been informed of the need for a physician's approval for my participation in exercise-related activity and the use of fitness room equipment.

I have read and understand this form in its entirety and do hereby waive, release, and forever discharge FCPA and its officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liabilities from injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above mentioned activities.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness – FCPA Staff Signature

\_\_\_\_\_  
Signature of Guardian if Minor