

# Rocket-Ex Registration Form - Summer 2009

## **A. PARTICIPANT INFORMATION** *(Please PRINT clearly – one registration form per participant.)*

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: \_\_\_\_\_ UT extension: \_\_\_\_\_

**Select Affiliation:**

- |   |   |
|---|---|
| <input type="checkbox"/> Faculty/Staff <i>full time</i> | <input type="checkbox"/> Health Science Campus Faculty/Staff            |
| <input type="checkbox"/> Faculty/Staff <i>part time</i> | <input type="checkbox"/> Spouse/Partner of current main campus employee |
| <input type="checkbox"/> Student                        | <input type="checkbox"/> Alumni   |
| <input type="checkbox"/> Community Member               | <input type="checkbox"/> Retired/Emeriti                                |

## **B. REGISTRATION CATEGORY** *(Please complete the section that applies to you.)*

### **1. Members & Students** *(walk-in classes are free of charge, \$30 to reserve a spot for the semester)*

This category includes everyone that will have a current SRC membership during the session for which they are registering (short term memberships are NOT included). This category also includes all current UT students, taking classes for credit during the session for which they are registering.

R # \_\_\_\_\_ **OR** Member # \_\_\_\_\_

### **2. Non - Members** *(you pay full price for Rocket-Ex classes)*

This category includes all participants who do NOT have a current SRC membership, but would like to take advantage of the fitness opportunities offered. This category may include community participants, Health Science Campus employees who do NOT wish to purchase a membership, or other affiliates such as Alumni, Retired or Emeriti who did NOT purchase a membership, but would like to participate in a class.

Member # \_\_\_\_\_

( If you do not have a member # previously assigned by the SRC, one will be assigned when you receive your ID card.)

## **C. CLASS INFORMATION** *(See the Fall 2008 Rocket-Ex Class Schedule.)*

| Class | Day(s) | Time  | Class Fee |
|-------|--------|-------|-----------|
| _____ | _____  | _____ | \$ _____  |
| _____ | _____  | _____ | \$ _____  |
| _____ | _____  | _____ | \$ _____  |

## **D. ID CARD, PARKING PASS AND PAYMENT INFORMATION**

\_\_\_ I need an **ID** (\$10 - Required unless you have a rocket card or SRC membership card.)

\_\_\_ I need a **parking permit** (\$22 - Lot 18 only)

**Payment due:** Total Class Fees \$ \_\_\_\_\_ + Parking \$ \_\_\_\_\_ + ID \$ \_\_\_\_\_ = **Total \$** \_\_\_\_\_

**OVER – Participants are required to read and sign the informed consent on the back of this form.**

### **OFFICE USE ONLY**

Date Received: \_\_\_\_\_ Amount \$ \_\_\_\_\_ Payment Type: \_\_\_\_\_

PAID: \_\_\_\_\_ SRC Staff Initials: \_\_\_\_\_

Registered: \_\_\_ Consent Signed: \_\_\_ ID: \_\_\_ Parking: \_\_\_ #visits: \_\_\_ encoded: \_\_\_ stats: \_\_\_

CONFIRMATION: Phone \_\_\_\_\_ or Email \_\_\_\_\_ Staff: \_\_\_\_\_

**NOTE:** Failure to legibly and fully complete forms will result in delayed or failed registration.

# Class Pricing:

The Yoga classes **require** payment from Members and Students as well as Non-members because they are in high demand, and are structured around a progressive learning program which requires consistent attendance.

Members & Students: \$25  
Non-Members: \$135

Cost includes one class per week

All other Rocket-Ex classes are free to Members and Students and are held on a first come, first serve basis. Members and Students **may** pay \$25 to **reserve** a spot for the semester as long as they arrive to class on time. Non members must pay \$105 per class for the semester:

## Rocket-Ex Informed Consent Form

There exists a risk to exercise participation including, but not limited to: abnormal blood pressure, fainting, irregular, fast or slow heart rhythm, stroke, heart attack, and/or death. I attest that I know and fully comprehend the importance and relevance of the material risk of exercise. I am of full sound mind and give consent voluntarily, and not under any mistake of fact or duress.

I further understand that any and all expense arising from an accident or injury to myself or to The University of Toledo property including, but not limited to, ambulance and emergency medical services, are my sole responsibility. I understand that the Office of Recreation at The University of Toledo strongly recommends that all participants have a physical examination before participation and further recommends that I purchase insurance to cover all accidents/injuries.

I hereby consent to voluntarily engage in an exercise program to increase the state of my health. My permission to perform exercise is given voluntarily. I understand that I am free to stop participation at any point, if I so desire.

Participant signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE; THE SECTION BELOW IS OPTIONAL. ANY ANSWERS GIVEN WILL REMAIN CONFIDENTIAL.**

Age: \_\_\_\_\_ Gender: F M Emergency contact and phone #: \_\_\_\_\_

1. Check and provide an **explanation** if you have any of the following conditions:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Arthritis/bursitis | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Past Heart attack  |
| <input type="checkbox"/> Back problems       | <input type="checkbox"/> Recent surgery     | <input type="checkbox"/> Past Heart surgery    | <input type="checkbox"/> Lung disease       |
| <input type="checkbox"/> Hernia              | <input type="checkbox"/> Heart murmur       | <input type="checkbox"/> Muscle disease/injury | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma/allergies   | <input type="checkbox"/> Joint injury/pain     | <input type="checkbox"/> Smoking history    |

**Explain:** \_\_\_\_\_

2. Have you ever experienced any of the following symptoms:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Chest pain/pressure | <input type="checkbox"/> Skipped/irregular heart beat | <input type="checkbox"/> Shortness of breath or unusual fatigue |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Fainting                     | <input type="checkbox"/> Seizures                               |

3. If you have checked **any** of the conditions listed above, has your physician approved you to exercise?

- No  Yes *\*If not, please consult with your physician before beginning an exercise program.*

4. Are you currently taking any medication, pills, or drugs?  No  Yes

If yes, please provide the **name(s)** of the medication and **reason(s)** for taking the medication.

Medication(s): \_\_\_\_\_