



# **Civilian Fitness Program**

## **Packet**

### **Class #11**

**Name:** \_\_\_\_\_



**Welcome to the Civilian Fitness Program! The first step in determining your level of fitness and insuring a lifetime of health and happiness starts here. Life is not about the amount of time that we live, but rather about the quality of that time.**

**You will receive a complete fitness assessment and evaluation of your current fitness level. This assessment will include a profile of your cardio-respiratory, absolute and dynamic strength, flexibility, and body composition. After all data is collected, our Physical Fitness Specialists will set-up a time with you to present you with your completed packet and offer guidelines on how to improve your level of fitness over the next six months in our structured program.**

**This completed packet is due in my office no later than Friday, 12 September 2008, 1600 hours. *Late packets will not be accepted for Class #11. The Physician Clearance Form must be completed, dated, stamped by your physician, and included when you submit your packet.***

**Your initial assessment will begin at 0730 hours on Monday, 22 September 2008. You will be given instructions on how to prepare and what to bring during the week of 15-19 September 2008 via e-mail. If you have any questions, please do not hesitate to contact me at 568-6458.**

**Sincerely,**

***Doug Briggs***

**Doug Briggs, Ph.D., CSCS  
Director of Strength & Conditioning-US ARMY/MWR**

# Health History Form

1. Date: \_\_\_\_\_  
2. Name: \_\_\_\_\_ Age: \_\_\_\_\_

3. Emergency Contact: (Name) \_\_\_\_\_  
(Name and Telephone number, including area code)

4. Resting Blood Pressure \_\_\_\_\_

## 5. Past and Present Personal Health History (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Disease of the Heart and Arteries | <input type="checkbox"/> Abnormal Electrocardiogram (EKG) |
| <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> Angina Pectoris (Chest Pain)     |
| <input type="checkbox"/> Epilepsy                          | <input type="checkbox"/> Stroke                           |
| <input type="checkbox"/> Anemia                            | <input type="checkbox"/> Abnormal Chest X-ray             |
| <input type="checkbox"/> Cancer                            | <input type="checkbox"/> Asthma                           |
| <input type="checkbox"/> Other Lung Diseases               | <input type="checkbox"/> Orthopedic or Muscular Problems  |
| <input type="checkbox"/> Diabetes (Type I or II)           | <input type="checkbox"/> Other                            |

If any of the above items are checked, please explain further and indicate any recommendations your doctor has made regarding exercise:

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## 6. Level of Physical Activity

- Yes  No  Are you currently involved in a regular aerobic exercise program such as walking, jogging, cycling, swimming, group fitness classes, etc?
- Yes  No  Are you currently participating in weight training?
- Yes  No  Do you perform stretching exercises?

What describes your level of physical activity during the past 4-6 weeks?

- Very Active
- Moderately Active
- Occasionally Active
- Inactive

7. Please indicate any additional information, which you think, is important for us to know prior to fitness testing and evaluation or exercise:

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8. Is there a family history of Heart Disease, Hypertension, Stroke, Diabetes, Heart Failure, Lung Disease, or Epilepsy? \_\_\_\_\_Yes \_\_\_\_\_No

If YES, please provide information regarding who the relative is, the medical problem, and the age at onset or death:

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9. \_\_\_\_\_ Yes \_\_\_\_\_ No Do you currently smoke?  
IF YES, how many cigarettes per day? \_\_\_\_\_

If you smoked in the past, when did you quit? \_\_\_\_\_

10. \_\_\_\_\_ Yes \_\_\_\_\_ No Are you currently taking medication prescribed by a physician?  
If, YES, indicate name of medication, dosage and reason for taking it:

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11. Please indicate any additional medical information that you think is important for us to know prior to fitness testing, evaluation or exercise:

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## **Physical Activity Readiness Questionnaire (PAR-Q)**

Name					Date		
DOB		Age		Home Phone		Work Phone or Cell	

Regular exercise is associated with many health benefits yet any change of activity may increase the risk of injury. Completion of this questionnaire is the first step when planning to increase the amount of physical activity in your life. Please read each question carefully and answer every question honestly: (Circle Yes or NO)

Yes	No	1) Has a physician ever said you have a heart condition and you should only do physical activity recommended by a physician?
Yes	No	2) When you do physical activity, do you feel pain in your chest?
Yes	No	3) When you were not doing physical activity, have you had chest pain in the past month?
Yes	No	4) Do you ever lose consciousness or do you lose your balance because of dizziness?
Yes	No	5) Do you have a joint or bone problem that may be made worse by a change in your physical activity?
Yes	No	6) Is a physician currently prescribing medications for your blood pressure or heart condition?
Yes	No	7) Are you pregnant?
Yes	No	8) Do you have insulin dependent diabetes?
Yes	No	9) Are you 69 years of age or older?
Yes	No	10) Do you know of any other reason you should not exercise or increase your physical activity?

If you answered **YES** to any of the above questions, talk with your doctor BEFORE you become more physically active. Tell your doctor your intent to exercise and to which questions you answered yes.

If you honestly answered no to all the questions you can be reasonably positive that you can safely increase your level of physical activity in a **gradual manner**.

If your health changes and you would answer **YES** to any of the above questions, seek guidance from a physician.

Participant's signature			Date	
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## **Informed Consent Form**

The undersigned hereby gives informed consent to engage in a series of procedures relative to completing a written medical/health history, taking a battery of exercise tests, and participating in a variety of physical activities. The testing purpose is to determine physical fitness, cardiovascular function, and health status. All exercise testing and physical activity sessions are voluntary and will be supervised and monitored by trained physical fitness specialists. The activities include, but are not limited to, walking, running, weight training, SPINNING, Yoga, Gravity, and calisthenic exercises performed in either a field or gymnasium.

There exists the possibility that certain detrimental physiological changes may occur during exercise and exercise testing. These changes could include heat-related illness, abnormal heart beats, and abnormal blood pressure, and in some instances, a heart attack. If abnormal changes were to occur, the staff has been trained to recognize symptoms and take appropriate action, including administering CPR and First Aid.

I have read this form and understand that there are inherent risks associated with any physical activity and recognize it is my responsibility to provide accurate and complete Health/Medical History information. Furthermore, it is my responsibility to monitor my individual physical performance during any activity. I understand that MWR/ Physical Fitness Specialists have reviewed my Health History form and when appropriate, make recommendations for me to modify my participation in physical activity during the course. I understand that it is my responsibility if I choose not to follow these recommendations.

In consideration of my application being accepted, I hereby, for myself, my heirs, personal representatives and executors waive, release and forever discharge and all rights and claims for loss or damages which I may have or hereafter accrue to me against the organizers and sponsors, for any and all injuries which might be suffered by me in this assessment. I attest and verify that I am able to start and complete this fitness assessment.

### **Physical Fitness Specialist (PFS) Initials.**

\_\_\_\_\_ The PFS recommends that you participate in any physical activity during this assessment.

\_\_\_\_\_ It is recommended by the PFS that you modify your participation in physical activity during the assessment so that you do not aggravate an existing medical condition.

In the event of a medical problem, I further recognize that any medical care that may be required is my personal responsibility

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE



## Physician Clearance Form

Please return this form to Doug Briggs. E-mailed and faxed forms are unacceptable. This form must be signed and dated by your physician.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**To the physician:** The individual named above has applied to the Fort Bliss Civilian Fitness Program. The program will involve a pre and post fitness assessment that includes a bioelectrical impedance analysis (BIA), the 3-minute step test, sit and reach test, tests of dynamic strength (1 minute timed sit-ups and push-ups), absolute strength (bench press on a selectorized machine) and 1 mile walk for time. The actual program will be 3 times per week in 1 hour blocks for a total of 6 months. Guidance will be provided on exercise program design, nutrition, and aerobics, but the actual program will be determined by the participant. Please complete the following:

I have examined \_\_\_\_\_ on \_\_\_\_\_.  
(Client's name) (Date of last exam)

I have found the following:

\_\_\_\_\_ he/she may participate fully in a physical activity program consisting of cardiovascular, strength, and flexibility training without limitation.

\_\_\_\_\_ he/she may participate in a physical activity program with the following limitations (please include a brief description of any medical condition which might affect his/her program with appropriate guidelines):

\_\_\_\_\_ he/she should not participate in any physical activity program at this time without first consulting a physician for further testing and guidance.

If your patient is on any medication "that" may affect the heart rate or blood pressure response to exercise (elevating or suppressing) please indicate here:

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

**Please note: This record must be stamped with the physician's official stamp or be accompanied by a typed letter on the physician's letterhead documenting that an evaluation has been performed on the named client. The Physician Clearance Form will not be accepted without such proper verification.**

## Employee Agreement

\* Make a copy for your records and return it to your supervisor. You are not enrolled until you are medically cleared for the assessment and complete the assessment to satisfactory standards. **Please print all items below legibly!**

Name of employee: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Work Phone: \_\_\_\_\_ FAX# \_\_\_\_\_

Name of Supervisor \_\_\_\_\_ E-mail \_\_\_\_\_

Organization \_\_\_\_\_

### **AGREEMENT**

1. We understand and agree that (employee name): \_\_\_\_\_ will be participating in the command-sponsored **CFP (Civilian Fitness Program)** for 3 one-hour sessions each week for a total of 72 hours over the consecutive 6 month period beginning on: **22 September 2008** and ending **23 March 2009**. **Wednesday, 24 September 2008 will be a full-day from 0800 to 1600 and is not figured into the 72 hours.** We understand and agree that the specified exercise location will be the place of duty during authorized periods, as follows: exercise periods will be on the following days of the week: Monday/Wednesday/Friday, at the following inclusive time: 1230\_ to 1430\_, and at the following location: Stout Gym.
2. We also understand and agree that:
  - a. The following are examples that may be individually amended or deleted according to the sponsoring Commander's/ Supervisors guidance. (This list is not necessarily all-inclusive).
    - ❖ Exercise days, times, and/or locations may be periodically amended only with prior approval of the Commander/Supervisor, and amendment of the agreement.
    - ❖ **Unused exercise hours may not be carried forward to subsequent weeks.**
    - ❖ The program end date will not be extended to make up for exercise periods missed because **LEAVE, TEMPORARY DUTY**, or other reasons.
    - ❖ No additional duty time is automatically authorized, as part of this program, i.e., Exercise Preparation (e.g. **Changing Clothes**) prior to exercise, **Personal Hygiene** or **Cooling Down** following exercise periods.
    - ❖ Specified exercise periods may not be used for non-duty purposes. Any period or portion thereof not used in actual fitness training and exercise will be spent in the normal duty workplace accomplishing normal duties.
    - ❖ Exercise periods are official duty time. Failure to appear, inappropriate use of exercise time, or misconduct during these periods would be considered as workplace infractions occurring during duty hours, and would be subject to the same disciplinary actions.
3. As a participant, I, the employee will sign-in and out on the exercise days with the Physical Fitness Specialist conducting the exercise program. I agree to file my workout tracking log with the Civilian Fitness Program instructors and will make available to my employer my attendance log upon demand.

**Signature of Employee** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Signature of Supervisor** \_\_\_\_\_ **Date** \_\_\_\_\_

## **What to Bring and Do for Your Fitness Assessment**

- 1. The fitness assessment will be done at Stout Gym. Meet in the lobby.**
- 2. Drink plenty of water (64 ounces or more) for three days before your assessment.**
- 3. Do not eat or exercise at least 4 hours before your testing.**
- 4. Immediately upon waking, before getting out of bed, take your pulse at the carotid artery continuously for 1 minute and record. The number of beats in one minute will constitute your resting heart rate and is necessary to calculate your exercise intensity.**
- 5. Be here at 7:15 a.m.**
- 6. Bring a protein bar or protein shake with you to be consumed after your body fat test.**
- 7. Bring a good pair of running or walking shoes and proper workout clothes (t-shirt, shorts, etc.).**
- 8. Bring a bottle of water (16 ounces).**
- 9. Last, but not least, bring a good attitude and have fun!**

## **Order of Events**

- 10. Overview and explanation to clients.**
- 11. Review of forms.**
- 12. Resting heart rate.**
- 13. Blood pressure testing.**
- 14. Body composition testing.**
- 15. Eat protein bar or drink protein shake.**
- 16. 5 minute break.**
- 17. 3 minute step test.**
- 18. Sit and reach test.**
- 19. Sit-ups.**
- 20. Push-ups.**
- 21. Bench press.**
- 22. 1 mile walk for time.**