Please complete and return the following forms to Clark College's Fitness Testing Lab as soon as possible in order to expedite the scheduling of your exercise test. The VO₂ assessment will determine your maximal aerobic capacity by scientifically measuring the rate at which oxygen can be distributed and utilized by the body during physical activity. A testing technician will discuss your results and personalized training plans will be outlined. Appointments are held in OSC Room 146.

**PERSONAL INFORMATION**

Gender: [ ] Male [ ] Female     Date of Birth: _____ / _____ / _____      Age: _______
Address: _____________________________________________ City: ______________________ State: _____ Zip: _________________
Day Phone: (______) _____ - ________ Evening Phone: (______) _____ - ________  Email: ______________________________

**MEDICATIONS**

List any prescribed medications you are currently taking and reason for taking each medication:
_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________

List any over the counter medications you are currently taking including herbal, supplements and NSAIDS such as Advil, Motrin, Tylenol, etc.:
_________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________

**EMERGENCY CONTACT**

Name: _______________________________________________   Relationship: _____________________________
Day Phone: (______) ______ - __________   Evening Phone: (______) ______ - __________
Primary Care Provider: _______________________________   Phone: (______) ______ - _________

**ACSM CORONARY ARTERY DISEASE RISK FACTORS**

**KNOWN DISEASES** Do you have any of the following? Please elaborate on any “yes” answers below.

<table>
<thead>
<tr>
<th>Category</th>
<th>Diseases</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>Cardiac, peripheral vascular, or cerebrovascular disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Chronic obstructive pulmonary disease, asthma, interstitial lung disease, cystic fibrosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metabolic</td>
<td>Diabetes mellitus (type I or II), thyroid disorders, renal or liver disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: ______________________________________________________________________________________________________________________

**SIGNS AND SYMPTOMS** Do you experience any of the following? Please elaborate on any “yes” answers below.

- Have you experienced unusual pain or discomfort in your chest (pain due to blockage in coronary arteries of the heart)?
- Have you experienced unusual shortness of breath during moderate exercise (such as climbing stairs)?
- Have you had any problems with dizziness or fainting?
- When you stand up, or sometimes during the night, do you have difficulty breathing?
- Do you suffer from swelling of the ankles (ankle edema)?
- Have you experienced a rapid throbbing or fluttering of the heart?
- Have you experienced severe pain in your leg muscles during walking?
- Has your doctor told you that you have a heart murmur?
- Have you felt unusual fatigue or shortness of breath with usual activities?

Comments: ______________________________________________________________________________________________________________________
## RISK FACTORS
To the best of your ability, check the appropriate yes/no box for each of the following questions.

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Defining Criteria</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
| Family History       | • Has your father or brother had a heart attack, stroke, or died suddenly of heart disease before the age of 55?  
  • Has your mother or sister had a heart attack, stroke, or died suddenly of heart disease before the age of 65? | ___ | ___ |
| Cigarette Smoking    | • Are you currently a cigarette smoker or have you quit within the past 6 months? | ___ | ___ |
| Sedentary lifestyle  | • Are you sedentary (i.e. not participating in at least 30 minutes of moderate intensity physical activity on at least three days of the week for at least three months)? | ___ | ___ |
| Obesity              | • Is your BMI of > 30 kg/m$^2$, OR  
  • Is your Waist girth > 40 in for men; > 35 in for women OR  
  • Is your Waist/Hip ratio: ≥0.95 for men and ≥0.86 for women? | ___ | ___ |
| Hypertension (high blood pressure) | • Is your systolic blood pressure over 140 or diastolic blood pressure over 90 mm Hg?  
  • Are you on medication to control your blood pressure? | ___ | ___ |
| Dyslipidemia         | • Is your LDL cholesterol level above 130 mg/dl (3.37 mmol-L$^{-1}$) OR  
  • Is your HDL cholesterol level below 40 mg/dl (1.04 mmol-L$^{-1}$) OR  
  • Is your Total Serum Cholesterol above 200 mg/dl (5.18 mmol-L$^{-1}$) OR  
  • Are you on lipid-lowering medication? | ___ | ___ |
| Pre-diabetes         | • Have you had fasting blood glucose measurements of ≥100 mg/dL confirmed on at least 2 separate occasions? | ___ | ___ |

**MUSCULOSKELETAL**, Please elaborate on any yes answers in the comments section below.

- Do you have any current musculoskeletal limitations that may impair your ability to perform maximal exercise (back pain; swollen, stiff, or painful joints; arthritis; fibromyalgia, etc.)?  

Comments: 

__________________________

**OTHER**

Please list and explain any other medical problems that you consider important for us to know:

__________________________

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### STAFF USE ONLY

**Resting:**  
HR: ___________   
Blood Pressure: ___________/___________

**Height:** ___________   
Weight: ___________   
BMI: ___________

**Risk Stratification (circle):**  
Low Risk   Moderate Risk   High Risk

**Signed Forms received:**  
___ Informed Consent/Acknowledgment of Risk

___ Cleared for maximal exercise

___ Cleared for sub-maximal exercise (70% HRR OR 85% Age pred. HR<sub>max</sub>)

Staff signature: ___________________________   
Date: ___________
INFORMED CONSENT FOR EXERCISE TESTING: (READ CAREFULLY BEFORE SIGNING!)

1. **Purpose and Explanation of the Test**
   You will perform an exercise test on a cycle ergometer or a motor driven treadmill. The exercise intensity will begin at a low level and will be advanced in stages depending on your fitness level. We may stop the test at any time because of signs of fatigue or changes in your heart rate, blood pressure, or symptoms you may experience. It is important for you to realize that you may stop when you wish because of feelings of fatigue or any other discomfort.

2. **Attendant Risks and Discomforts**
   There exists the possibility of certain changes occurring during the test. These include abnormal blood pressure, fainting, irregular, fast or slow heart rhythm, and in rare instances, heart attack, stroke, or death. Every effort will be made to minimize these risks by evaluation of preliminary information relating to your health and fitness and by careful observations during testing. Emergency equipment and trained personnel are available to deal with unusual situations that may arise.

3. **Responsibilities of the Participant**
   Information you possess about your health status or previous experiences of heart-related symptoms (such as shortness of breath with low-level activity, pain, pressure, tightness, heaviness in the chest, neck, jaw, back and/or arms) with physical effort may affect the safety of your exercise test. Prompt reporting of these and any other unusual feelings with effort during the exercise test itself are of great importance. You are responsible for fully disclosing your medical history, as well as symptoms that may occur during the test. You are also expected to report all medications (including non-prescription) taken recently and, in particular, those taken the day of testing, to the staff.

4. **Benefits to be Expected**
   The results obtained from the exercise test will determine your maximal aerobic capacity by scientifically measuring the rate at which oxygen can be distributed and utilized by the body during physical activity. A testing technician will discuss your results and personalized heart rate training zones will be defined. Clark College’s fitness testing staff are not medical doctors and are not qualified to diagnose a participant’s illness or state of disease.

5. **Inquires**
   Any questions about the procedures used in the exercise test or the results of our test are encouraged. If you have any concerns or questions, please ask us for further explanations.

6. **Use of Medical Records**
   The information that is obtained during testing will be treated as privileged and confidential. It will not be released or revealed to any person without your approval.

7. **Eligibility**
   Only individuals determined to be “low risk” based on ACSM’s risk stratification guidelines may perform maximal testing. Individuals determined to be “moderate risk” may only participate in sub-maximal testing.

8. **Acknowledgement and Consent**
   I expressly acknowledge that the exercise test is done for information purposes and not for the purpose of diagnosing or treating injuries or illnesses, and that the exercise test and any results does not in any way declare whether I am fit to utilize the fitness center. I hereby consent to voluntarily engage in an exercise test to determine my exercise capacity and state of cardiovascular health. My permission to perform this exercise test is given voluntarily. I understand that I am free to stop the test at any point, if I so desire.

BY MY SIGNATURE BELOW I UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Print Name: __________________________ Signature: __________________________ Date: __________

Parent/Guardian Name: __________________________ Signature: __________________________ Date: __________

(If under 18 years, parent or guardian signature is required)

OVER
1. I hereby acknowledge that I have voluntarily chosen to participate in the VO2 max and sub-max metabolic testing (exercise testing) through Clark College’s fitness testing lab.

2. I am aware that Clark College’s fitness testing lab staff are not medical doctors and are not qualified to determine a participant’s physical capability to engage in strenuous exercise.

3. The information given on the medical history questionnaire is correct to the best of my knowledge. I understand that absence of the physical problems listed on this form does not necessarily guarantee that I am in satisfactory health to participate in an exercise test.

4. Acknowledgment of Risk. I understand and acknowledge the risks involved in participating in exercise testing at Clark College’s fitness testing lab, including, but not limited to, the risks involved in utilizing equipment or participating in any exercise or fitness activity. I have been informed that these risks, though remote include abnormal blood pressure, fainting, disorders of heart rhythm, stroke, and very rare instances of heart attack or even death. While I have been assured that every effort will be made to minimize these occurrences by precautions taken during testing. I have also been informed that emergency equipment (First Aid Kit/AED) and trained personnel are available to deal with these unusual situations should they occur, I understand that the fitness testing lab does not employ medical professionals.

5. Assumption of Risks. I understand that I am responsible for researching and evaluating the risks that I may face and am responsible for my actions. I also understand that if I have any doubts of my physical or mental condition, I am responsible for discussing the activities and risks involved in the exercise test with my physician. Any activities that I may take part in, whether as a component of the exercise test or separate from it, will be considered to have been undertaken with my approval and understanding of any and all risks involved.

I agree to expressly assume and accept any and all risks associated with the exercise test, including but not limited to, travel to/from the testing lab facilities and limited availability of medical aid. By voluntarily participating in exercise testing with the knowledge of the risks involved, I hereby agree to accept any and all inherent risks of property damage, bodily injury or death.

6. Release, Indemnification and Hold Harmless. In consideration for being allowed to participate in the VO2 max and sub-max metabolic testing (exercise test) offered in the Clark College’s fitness testing lab and to the fullest extent permitted by law, I agree to indemnify, defend and hold harmless Clark College, its trustees, officers, employees, volunteers, agents and assigns from and against all claims arising out of or resulting from my participation in the exercise test, except for claims arising out of the sole negligence or willful misconduct of Clark College, its trustees, officers, employees, volunteers, agents and assigns.

“Claim” as used in this agreement means any financial loss, claim, suit, action, damage or expense, including but not limited to attorney’s fees, attributable to bodily injury, sickness, disease or death, or injury to or destruction of tangible property including resulting loss of use. In addition, I hereby voluntarily release, forever discharge and agree not to sue Clark College, its trustees, officers, employees, volunteers, agents and assigns from any and all claims, both present and future, that may be made by me, my family, estate, heirs or assigns.

I further understand that this acknowledgment of risk and hold harmless is intended to be as broad and inclusive as permitted by the laws of the State of Washington, or any other applicable laws, and that if any portion hereof is held invalid, I agree that the remainder shall, notwithstanding, continue in full legal force and effect.

I HAVE READ AND FULLY UNDERSTAND THIS ACKNOWLEDGMENT OF RISK AND HOLD HARMLESS AGREEMENT.

Print Name: __________________________ Signature: __________________________ Date: ______________

Parent/Guardian Name: __________________________ Signature: __________________________ Date: _________

(If under 18 years, parent or guardian signature is required)

Thank you for taking the time to complete and return this form prior to your test!