

SOUTHERN HEALTH SANTE SUD PARAMEDIC FITNESS ASSESSMENT REGISTRATION FORM

Applicant Information

Name: _____ Date of Birth: _____ Gender: Male ☐ Female ☐
Phone Number: _____ Work/Cell Phone: _____
Address: _____
City: _____ Postal Code: _____
Email: _____
Emergency Contact: _____ Emergency Contact Phone: _____
Family Physician: _____ Physician Phone: _____
Physician Address: _____

REGISTRATION INFORMATION

- **\$120 per test**
- **PAR-Q form is REQUIRED at the time of registration**
- Test duration is approximately 2 hours
- Refunds less a \$15 administration fee will be granted ONLY when a valid medical certificate is presented
- Transfer requests received 4 or more working days prior to the scheduled test will be granted if there is space (no transfer fee)
- Payment is non-transferable from person to person
- In person, fax and mail registration ONLY – **NO TELEPHONE REGISTRATION**
- Payment options include: cash, Interac, Visa, MasterCard, cheque * *post-dated cheques are NOT accepted*

The Releasor hereby authorizes the University to take photograph/video of the Participant during program/membership activities, and to display and otherwise use these images without charge solely for the purpose of promotional material in connection with the University.

APPOINTMENT INFORMATION

Applicant Preferred Testing Date: _____
CSRs Record Booked Appointment: Date: _____ Time: _____

Contact Info

Registration Inquiries:	1-800-432-1960 (ex 6100)	(204) 474-7864	www.uofmactiveliving.ca
Test Specific Inquiries:	1-800-432-1962 (ex 6476)	(204) 474-6476	ulla.liljegren@ad.umanitoba.ca

OFFICE USE ONLY

CSR Received:	<input type="checkbox"/> Cash	Date Received: _____
<input type="checkbox"/> Registration Form	<input type="checkbox"/> Cheque	Amount Received: _____
<input type="checkbox"/> PAR Q Form	<input type="checkbox"/> Interac	Processed By: _____
<input type="checkbox"/> Payment	<input type="checkbox"/> Visa	Date: _____
	<input type="checkbox"/> MasterCard	Notified: <input type="checkbox"/> in Person <input type="checkbox"/> Phone <input type="checkbox"/> Other

PAYMENT INFORMATION

In Person/Mail: Customer Service Desk, 145 Frank Kennedy Centre, University of Manitoba, R3T 2N2

Fax: (204) 474-7503 (include Visa or MasterCard information including expiry date)

Total Amount Due: \$ _____ Expiry Date: _____
Visa/MasterCard #: _____ Signature: _____

Physical Activity Readiness Questionnaire (PAR-Q)

Common sense is your best guide when you answer these questions. Please read the questions carefully, and answer each one honestly: circle YES or NO

- | | | | |
|----|--|-----|----|
| 1. | Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? | YES | NO |
| 2. | Do you feel pain in your chest when you do physical activity? | YES | NO |
| 3. | In the past month, have you had chest pain when you were not doing physical activity? | YES | NO |
| 4. | Do you lose your balance because of dizziness or do you ever lose consciousness? | YES | NO |
| 5. | Do you have a bone or joint problem that could be made worse by a change in your physical activity? | YES | NO |
| 6. | Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? | YES | NO |
| 7. | Do you know of <i>any other reason</i> why you should not do physical activity? | YES | NO |

If you answered **YES** to any of the above questions, you **must** obtain a medical clearance by a physician before we will allow you to access the facilities / programs. A medical clearance form may be obtained from the Customer Service Desk.

I hereby release and discharge The University of Manitoba, The Faculty of Kinesiology and Recreation Management, and the employees of the aforementioned (The 'University') from any and all claims, and demands by me and my heirs, executors, or assigns, for, upon, or by reason of any damage, loss, or injury to my person property, or dependent children which may be sustained as a consequence of my participation in any activity or through the negligence of act of omission of the university in these facilities.

DATE

PARTICIPANT NAME (please print)

SIGNATURE



UNIVERSITY
OF MANITOBA

Faculty of Kinesiology and Recreation Management
Recreation Services