Applicant Name_____

Application Packet

Presented By:

DISCOVER Plattsburgh
City Recreation Center

Applications must be returned to the City Recreation Center (52 US Oval) by:
4pm September 19, 2017.

As an applicant, you understand and assert the following:

1. You are 18 or older.
2. If selected, you are available Tuesdays and Thursdays from 5pm-7pm and will attend at least one more workout each week on your own at the City Recreation Center from **October 10, 2017** through **April 5, 2018**. NO EXCEPTIONS.
3. The first meeting date will be on **Saturday October 7, 2017** .
4. This is not the TV show. There is no competition. We strive for reasonable and SAFE weight loss and implement various educational initiatives as well.
5. You will pay the $125 trainer fee (this is the only expense for acceptance into the program).
6. Applicants who are accepted into the program will be called on **September 26, 2017**.

Questionnaire

Please answer all questions **honestly** and to the best of your ability.

Name:_____ Date:___/___/___

Address: _____

_____

Height: ____ feet ____ inches Age:_____ Weight:_____ pounds

T-Shirt Size: _____

Phone Number: _____

Email Address: _____

Physicians Name: _____

Physicians Number: _____

Emergency Contact Name: _____

Emergency Contact Phone #: _____

PHYSICAL ACTIVITY QUESTIONS:

	Questions	Yes	No
1	Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?		
2	Do you feel pain in your chest when you perform physical activity?		
3	In the past month, have you had chest pain when you were not performing any physical activity?		
4	Do you lose your balance because of dizziness or do you ever lose consciousness?		
5	Do you have a bone or joint problem that could be made worst by change in your physical activity?		
6	Is you doctor currently prescribing any medication for your blood pressure or for a heart condition?		
7	Do you know of any other reason why you should **NOT** engage in physical activity		

When seeing your doctor for your medical evaluation go over these questions with them, seek advice from your physician on what type of physical activity is suitable for your current condition(s).

GENERAL & MEDICAL QUESTIONS:

	Questions	Yes	No
1	What is your current occupation?		
2	Does your occupation require extended periods of sitting?		
3	Does your occupation require extended periods of repetitive movement?		
4	Do you smoke? If yes would you like to quit?		
5	Do you consume more than 2 alcoholic beverages per day?		
6	Do you partake in any recreational activities (golf, tennis, skiing, etc)? If yes, please list: _____ _____ _____		
7	Do you have any hobbies (reading, gardening, working on cars, internet surfing)? If yes please list: _____ _____ _____		
8	Have you ever had any chronic pain or injuries (ankle, knee, hip, back, shoulder, etc.)? If yes please list: _____ _____ _____		
9	Have you ever had any surgeries? If yes please list:		

The following section must be completed by your doctor.

PHYSICIAN'S AUTHORIZATION:

Participants Name:_____

Date:_____

I authorize that the above named individual is able to participate in physical activity and is taking no medication(s) or does not have any known existing medical conditions that should prevent him/her from participating in The City of Plattsburgh Recreation Department's North Country's Biggest Loser Program.

I understand that the individual will be unsupervised at times while participating in some of the exercise activities. If I, the physician, have questions about the equipment or exercise facility, it is the responsibility of the participant to provide me with the necessary information.

Physician Name (Please Print):

Physician Signature/ Date:

Physician License #:

	Questions	Yes	No
10	Has a medical doctor ever diagnosed you with a chronic disease, such as coronary heart disease, coronary artery disease, hypertension (high blood pressure), high cholesterol or diabetes? If yes explain: _____ _____ _____		
11	Are you currently taking any medication? If yes, please list: _____ _____ _____		
12	Do you have any allergies or medical conditions? If yes, please list: _____ _____ _____		
13	Have you ever been treated for any serious physical or mental illnesses or had any serious injuries? If yes please describe: _____ _____ _____		
14	Do you have any physical conditions, special needs, or fears that we should know about? If yes please describe: _____ _____ _____		
15	Have you ever been convicted of a violent offense or a felony? If yes, please provide details: _____ _____ _____		

General Questions	
1	Do you have any other family members who are also overweight? Yes / No If so, please list their relationship to you. _____ _____ _____
2	Describe your job history, and what you currently do? _____ _____ _____
3	How would someone who really knows you describe your best qualities? _____ _____ _____
4	How would someone who really knows you describe your worst qualities? _____ _____ _____
5	Give us a brief synopsis of your dieting history: _____ _____ _____
6	What is your greatest accomplishment? _____ _____ _____
7	What is something we would not know by looking at you? _____ _____ _____

8	My favorite restaurant is:
9	Describe your favorite meal:
10	Describe what Food means to me: ex. Provides comfort, provides nutrition..
11	Describe what Exercise means to me: (ex. Hate it, love it, would like to learn more about it)
12	Describe what your current weight means to you:
13	How much weight do you want to lose?
14	What would motivate you to lose weight?
15	What do you think would be the best thing about being healthy?

16	What is the hardest thing about being overweight?
17	Do you have any bad habits you wish you could change?
18	Do you feel you have someone close to you who would support your weight loss goals? Yes / No Comment

Tell us why you should be chosen for the North Country Biggest Loser Program. Please be specific (Why would you be a good candidate? Include life goals, fitness goals, health information, etc.). Please use additional paper if necessary.

By signing below, I hereby represent, warrant, acknowledge and agree that: (i) I have completed this application honestly, accurately and to the best of my ability. (ii) if any information in this application is found to be false or incomplete this can be grounds for dismissal from the North Country's Biggest Loser constant selection process, and/or from the contest.

Signature/Date:

Name (please print):

North Country's Biggest Loser

1. The City of Plattsburgh Recreation Department requires all participants chosen to participate in the North Country's Biggest Loser Program consult with their personal physician before undertaking an exercise routine. Participation in this contest is voluntary.

2. Participants agree to follow Biggest Loser Program guidelines. Violation of these guidelines may be cause for suspension from the program and the use of the facilities.

3. The City of Plattsburgh Recreation Department is not responsible for any injuries or illnesses that may occur as a result of participation in the program. Participants hereby knowingly and voluntarily waive any right of cause action of any kind whatsoever arising from the use of this facility, the exercise equipment or the wellness program.

4. If participants have questions about the equipment, exercise facility, or wellness program it is the responsibility of the participant to seek necessary information.

CITY OF PLATTSBURGH
ASSUMPTION OF RISK
For Persons Participating in the North Country Biggest Loser Program

Activity/Event: Location: City of Plattsburgh Recreation Department
Participant Name: (Print)
Date of Birth:
Home Address:
Phone:

The undersigned participant and his or her parents or legal guardian, if participant is under the age of eighteen (18), does (do) hereby execute this Assumption of Risk for himself (herself) (themselves), and his (her) (their) heirs, successors, representatives and assigns, and hereby agree(s) and represent(s) as follows:

I am aware that during my participation in: the **North Country Biggest Loser Program,** under the arrangements of: the City of Plattsburgh Recreation Department**,** certain dangers may occur, including but not limited to: the danger of heart attack, stroke, other cardio vascular health problems, and injuries to muscles, tendons, joints that may be precipitated or caused by exercise activities engaged in by a person in my general health condition.

I understand that exercise activity by a person in my physical condition is an inherently dangerous activity and that the risks associated with this activity are generally recognized as dangerous. In consideration of the right to participate in the specific event referenced above, I have and do hereby hold City of Plattsburgh, and its employees, agents and contract service providers harmless from any and all liability, actions, causes of action, debts, claims, demands of every kind and nature whatsoever which may arise of or in connection with the specific event/activity referenced above. The terms thereof shall serve as a release and assumption of risk for my heirs, executor and administrators and for all members of my family, including minors accompanying me.

I understand that the specific event or activity referenced above has many inherent risks from the standpoint of being basically a physical sport and/or activity. I acknowledge these risks and voluntarily agree to participate in this event/activity as referenced above at my own risk. I understand that if I require immediate medical treatment there may not be medical personnel on premises to provide immediate assistance. I understand the City of Plattsburgh will respond to any such emergency by calling 911, but it cannot guarantee or give any assurance as to the response time of emergency medical personnel.

I, the undersigned, have read this Assumption of Risk and understand its terms and the risks involved and accept these risks. I understand and agree by my signature hereon that I have had the opportunity to discuss this document with anyone that I might choose and that I freely sign it.

_____

Signature of Participant
(Print Name) :
Date:

CITY OF PLATTSBURGH
MEDICAL CONSENT
For Persons Participating in the North Country Biggest Loser Program

I, _____,hereby grant City of Plattsburgh authority to consent to medical treatment on my behalf should the above named become ill, injured or otherwise incapacitated while participating in the above activity. The City or its agents and employees may:

1. make any arrangements that are appropriate and in my best interests upon injury and incapacitation, for emergency medical, surgical or dental care;
2. consent in my name to any and all types of medical treatment or procedures, dental treatment or procedures or surgical procedures**;**
3. consent in my name to the disclosure of any confidential or privileged communication or information related to the rendering of any care**;**
4. employ physicians, surgeons, nurses, dentists, or any other individual or institution necessary in order to render any of the types of care authorized by this Medical Consent.

A photocopy of this instrument shall be deemed an original for all purposes.
THIS MEDICAL CONSENT FORM EXPIRES UPON THE CONLUSION OR TERMINATION OF THE ABOVE PROGRAM OR ACTIVITY OR THE PARTICIPANT'S WITHDRAWAL FROM SUCH PROGRAM OR ACTIVITY.

If any part of this Medical Consent Form is held to be invalid under any law, the remainder of this instrument shall not be affected by such invalidity.

IN WITNESS WHEREOF, I have executed this Medical Consent Form on _____, 20 .

_____
Participant's Signature
(Print Name) _____

Date _____

Completed registration and authorization forms are to be returned directly to City of Plattsburgh Recreation Department.

INFORMED CONSENT FORM
Department of Nursing and Nutrition
State University of New York College of Plattsburgh

Project Title: The Biggest Loser Program

Principal Investigator: Priyanka Chakraborty, PhD, RD

Purpose of Study
As a participant of the Biggest Loser Program, I am being asked to participate as a subject in a research study from the Department of Nursing and Nutrition, State University of New York College of Plattsburgh. The purpose of this study is to evaluate the short and long term effects of the Biggest Loser program on weight loss, eating habits and other indicators such as blood pressure, blood lipids and glucose.

Study Procedure
If I choose to participate, the evaluation will take place thrice during the program (beginning, mid-point and end of the program) and 3 months following the completion of the program. This will involve an interview in English and body composition measurements of me. I can refuse to participate in any of the tests listed in the consent form.

The Body Composition and Health Status Measurements to be made

Weight, height, percent body fat and body mass index
Waist and hip circumference
Blood Pressure
Fasting blood glucose and blood lipid

If I agree to participate, I will be asked questions that will assess my health, lifestyle and dietary habits as well as the socioeconomic condition of my household. My interview will be followed by anthropometric (weight, height, waist circumference, hip circumference), blood pressure, blood glucose and blood lipid measurements. My weight, height, percent body fat and body mass index will be measured using the TANITA Body Composition analyzer and a Stadiometer while my waist and hip circumference will be measured using a non-elastic tape measure. I expect that the interview will take about 20 minutes while the body composition measurements will take about 20-30 minutes of my time. Fasting blood glucose and lipids will be measured by Cardio Check PA Professional Blood Testing device using finger prick.

<u>Benefits</u>
All participants will be provided with the results of all measurements taken at the end of the body composition measurements. Finding from this study will be used to evaluate the impact of the program and make necessary changes accordingly.

<u>Economic Considerations</u>
I understand that there will be no compensation for my time upon completion of the interview and all measurements.

Confidentiality

All the information collected through this project will be kept in a secure place at the Department of Nursing and Nutrition, SUNY-Plattsburgh. Only highly trained staff members working for the research project will have primary access to this information. The researchers will not use my name, address, telephone number or nay other identification information in any publications or reports of this project, my identity will remain completely confidential.

Risk and Discomforts

There are no foreseeable risks or discomforts associated with participating in this research study. Should I become uncomfortable at any stage during the body composition measurements, I will make sure to verbalize this to the investigator and the measurements will be discontinued immediately on request until I am able to continue.

My Participation

My participation in this study is completely voluntary, and I do not have to answer questions I do not wish to. I am free to withdraw from the study at any time. If I choose not to participate, it will not affect me or my family in any way or form. There will be no cost to me for participating in this study regardless of the length of time I choose to participate.

Questions?

If I have any questions or concerns, I will contact the principal investigator of this study Dr. Priyanka Chakraborty at (518) 564-4268 or email her at pchak001@plattsburgh.edu

Authorization:

I have read this form and decided that I, _____

(*name of participant)*

will participate in the project described above. Its general purposes, the particulars of involvement and possible risks and inconveniences have been explained to my satisfaction. My signature also indicates that I have received a copy of this consent form.

Signature of participant: _____

Date: _____

Signature of PI: _____

Printed name of PI: _____

Please fill out the following to the best of your ability. This form will be handed over to emergency personnel in case of emergency, so it is important that all of the information is accurate.

Full Name:_____

Date of Birth: _____/_____/_____ Age:_____

Weight:_____ Height_____

Physician's Name: _____

Physician's Phone #:_____

Emergency Contact #1: NAME:_____

PHONE:_____

Emergency Contact #2: NAME:_____

PHONE:_____

Do you have any allergies? If so, please list: _____

_____

_____

Do you have any medical conditions?_____

_____

_____

Please list any medications that you take and their dosages. Please feel free to use the back of this form.

_____

_____