K-STATE
Research and Extension

Stay Strong, Stay Healthy

Participant Enrollment

Name: _____

Best phone number: _____ Email: _____

Age and year of birth: _____ Gender: _____

In case of emergency, please call (please list two contacts):

Name: _____

Relation: _____ Phone number: _____

Name: _____

Relation: _____ Phone number: _____

Follow-up survey for first time participants:

Are you willing to participate in a three-month follow-up survey? ❑ Yes or ❑ No

If yes, may we send the survey via email? ❑ Yes or ❑ No, please send via mail

Street Address: _____

City: _____ State: _____ ZIP: _____

At _____, we want to make sure we are presenting our programs to a wide range of participants. This information is voluntary and confidential, and will be used to identify our audiences in general.

Race

- ❑ American Indian/ Alaskan Native
- ❑ Asian
- ❑ Black or African-American
- ❑ Native Hawaiian or other Pacific Islander
- ❑ White
- ❑ Two or more races/Other
- ❑ Unknown

Hispanic

❑ Yes ❑ No

Veteran status

- ❑ Nonveteran
- ❑ Veteran
  - ❍ Vietnam Veteran
  - ❍ Other

Disabled

❑ Yes ❑ No

I need to tell you...

Here's where you can put any pertinent health conditions that you think the instructor needs to know.

--- Below is for instructor use only ---

Program site: _____

County: _____

Start date: _____

Returning participant initial if all responses are the same ____ Date _____

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For instructor use. Valid for one year.

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PAR-Q

Physical Activity Readiness Questionnaire

Participant Name: _____

Regular exercise is associated with many health benefits, though any change of activity may increase the risk of injury. Complete this questionnaire as a first step toward increasing the amount of physical activity in your life. Please read each question carefully and answer every question honestly:

YES	NO	
☐	☐	1. Has a physician ever said you have a heart condition and that you should only perform physical activity recommended by a physician?
☐	☐	2. Do you feel pain in your chest during physical activity?
☐	☐	3. In the past month, have you had chest pain at a time when you were not doing physical activity?
☐	☐	4. Do you ever lose consciousness or do you lose your balance because of dizziness?
☐	☐	5. Do you have bone or joint problems (back, knee or hip) that may be made worse by a change in your physical activity?
☐	☐	6. Is a physician currently prescribing medications for your blood pressure or a heart condition?
☐	☐	7. Are you 69 years of age or older?
☐	☐	8. Do you know of any other reason why you should not exercise or increase your physical activity?

If you answered "yes" to any of the above questions, please request that your doctor complete a Physician Authorization Form before beginning a Stay Strong, Stay Healthy class. Your instructor can provide the form to you or your physician.

If you honestly answered "no" to all questions, you can be reasonably sure that you can safely and gradually increase your level of physical activity.

Note: This PAR-Q is valid for a maximum of 12 months from the date it is completed. If at any time your medical condition changes, you must complete a new PAR-Q and the previous one becomes invalid.

Participant signature _____ Date _____

Returning participant initial if all responses are the same ____ Date _____

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Participant Consent

I have voluntarily enrolled in a program of progressive exercise and understand that I may choose to quit the program at any time. The program is designed to place a gradually increased workload on the heart, lungs, muscles and bones to help improve their function. I understand that participation in such a program may be associated with some risks. These risks may include but are not limited to muscle soreness, fainting, disorders of heart beat, abnormal blood pressure, and in very rare instances, heart attack. To the best of my knowledge I do not have any limiting physical conditions or disability that would preclude an exercise program. Effort will be made to minimize any risks to me by a pre-exercise assessment and a medical screening. If my medical status changes during the program, I will inform the program leader and my health care provider to see if is safe to proceed with the program. That in consideration of my participation in this program, I agree, on behalf of myself, my assigns, executors, and heirs, to release and hold harmless AlexanderwholMennonite Church and the University of Missouri and Kansas State University, and their trustees, officers, employees, and agents from any and all liability, damage, or claim of any nature whatsoever arising out of my participation. I assume all risks and responsibility for any injury, damage, or any other adverse event that may result from my participation in this program.

Before I begin this program I understand that a pre-exercise assessment and physician screening consent form will be required. I understand that each person may react differently to these fitness activities and these reactions cannot be predicted with complete accuracy. I will inform the program leader and/or my health care provider if I experience any unusual symptoms.

I understand that the benefits to me of participating in this program may include increased strength and, as a result, improved health. I understand that this program will be evaluated for future program improvement and results may be published, but that at no time will my individual results be identifiable in such reports.

I understand that if I have any questions about my involvement in the evaluation of this program, I may contact Dr. Paula Peters, 340 Justin Hall, Kansas State University, Manhattan, KS 66506. Phone: 785-532-1562. I may also contact Dr. Rick Scheidt, Chair of Committee on Research Involving Human Subjects, 203 Fairchild Hall, Kansas State University, Manhattan, KS 66506. Phone: 785-532-3224.

PUBLICITY RELEASE

- ❑ I authorize Kansas State Research and Extension to record and photograph my image and/or voice for use in research, educational and promotional programs. I also recognize that these audio, video and image recordings are the property of Kansas State Research and Extension.
- ❑ No, I do not authorize the use of my individual image or voice.

Signature: _____

Printed Name: _____

Date: _____

Returning participant initial if all responses are the same ____ Date ____

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pre-disabled and veteran employer
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Stay Strong, Stay Healthy

Physician Cover Letter

Physician Name: _____

Hospital/Clinic Affiliation: _____

Phone Number: _____

Fax Number: _____

Date: _____

Dear Dr. _____:

Your patient, _____, is interested in participating in the ***Stay Strong, Stay Healthy Program***. This moderate-intensity, progressive exercise program includes strength and balance training and is designed to improve muscle strength, dynamic balance and flexibility.

This program is based upon the results of strength training studies in older adults conducted by scientists at the John Hancock Center for Physical Activity and Nutrition at the Gerald J. and Dorothy R. Friedman School of Nutrition Science and Policy at Tufts University in Boston, Mass. Scientists and exercise physiologists at Tufts University have designed this exercise program especially for midlife and older adults. Kansas State University Research and Extension agents are implementing the program in _____. Your patient will be required to provide informed consent prior to participation in this exercise program.

Please complete and sign the enclosed Physician Authorization Form. If you have any questions or would like to discuss your patient's participation in the program in further detail, please call me at _____.

Sincerely,

K-STATE Research and Extension

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Stay Strong, Stay Healthy

Physician Authorization Form

Patient's Name: _____ Birth Year: _____

❑ Yes, my patient can participate.

❑ Yes, my patient can participate with the following limitations:

❑ No, my patient cannot participate at this time because of their medical conditions and health status.

Physician's signature: _____

Print name: _____ Date: _____

Phone number: _____ Fax: _____

This form may be given to the patient, OR sent to the course instructor at:

Please return this form by: _____

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Pre-Course Survey

1. **Participant ID** _____

2. **Age** _____

3. **Gender** *(for program analysis and improvement)* _____

4. **SSSH instructor name** _____

5. **County and state in which SSSH course was held**

   County _____ State _____

6. **How many days per week do you currently engage in the following?**

	None	1 day per week	2-3 days per week	4+ days per week
Strength training exercises	❑	❑	❑	❑
Aerobic activities such as walking, swimming, biking, etc.	❑	❑	❑	❑
Stretching or flexibility exercises	❑	❑	❑	❑
Balance exercises, such as yoga or tai chi	❑	❑	❑	❑

7. **I describe my knowledge, skills and understanding of strength training exercise as:**
   - ❑ Extremely adequate
   - ❑ Somewhat adequate
   - ❑ Neither adequate nor inadequate
   - ❑ Somewhat inadequate
   - ❑ Extremely inadequate

8. Please rate your concern about falling while doing the following activities. If you currently do not do the activity, please answer to show whether you think you would be concerned about falling IF you did the activity.

	Very concerned	Fairly concerned	Neutral	Somewhat concerned	Not at all concerned
Getting dressed or undressed	❑	❑	❑	❑	❑
Taking a bath or shower	❑	❑	❑	❑	❑
Getting in or out of a chair	❑	❑	❑	❑	❑
Going up or down stairs	❑	❑	❑	❑	❑
Reaching for something above your head or on the ground	❑	❑	❑	❑	❑
Walking up or down an incline or uneven surface	❑	❑	❑	❑	❑
Going out to a social event (e.g., religious service, family gathering, movie or restaurant)	❑	❑	❑	❑	❑

9. Please indicate to what extent the following items are affected by your health:

	A great deal	A lot	A moderate amount	A little	None at all
Does your energy level limit you from completing everyday tasks?	❑	❑	❑	❑	❑
Does your health limit you in moderate activities, such as housecleaning, pushing a vacuum, golf, bowling or moving a table?	❑	❑	❑	❑	❑
Does your health limit you when climbing several flights of stairs?	❑	❑	❑	❑	❑

10. Regarding your current health status *(you may skip this question if you prefer to not answer):*

	Are you currently being treated for any of the following conditions (you may select more than one)	Indicate if this condition is currently being controlled with medication	
	Yes	Yes	No
Hypertension	❑	❑	❑
Heart Disease	❑	❑	❑
Type 2 Diabetes	❑	❑	❑
High Cholesterol	❑	❑	❑
Arthritis	❑	❑	❑
Atherosclerosis	❑	❑	❑
Osteoporosis	❑	❑	❑
COPD	❑	❑	❑
Depression	❑	❑	❑
Insomnia or Sleep Apnea	❑	❑	❑
Obesity	❑	❑	❑
Metabolic Syndrome	❑	❑	❑
Other	❑	❑	❑

Thank you for taking the time to fill out this survey.