

INFORMATION FOR PARTICIPANTS PRIOR TO THEIR SHUTTLE RUN ASSESSMENT DATE

In preparation for assessment, participants should be aware of the following:

- Arrival Time: Arrive at the assessment site at least 30 minutes prior to your appointment to allow your blood pressure to return to the resting level. You will complete a “Performance Declaration” with your appraiser on the day of your assessment
- Bring with you: Please bring your completed PAR-Q+, (and if required, the directive from the on-line ePARmed-X+ at www.eparmedx.com) (Warburton et al 2015) You also need to bring your Participation Consent for PREP Assessment, as well as your Release, Waiver and Indemnity form. You will need to **bring government issued photo identification**
- Exercise Attire: Please attend wearing your exercise clothing
- Smoking: Do not smoke for two hours prior to you test
- Food and Beverages: Do not eat a large meal at least 2 hours prior to the assessment. Refrain from drinking caffeinated beverages 6 hours before the assessment and alcoholic beverages 24 hours before the assessment
- Exercise: Do not exercise vigorously in the 24 hours prior to the assessment
- Be advised that if you give any untruthful or misleading answers when completing the required forms, you may be found unsuitable for employment you could face disciplinary action or even dismissal



YORK REGIONAL POLICE
UNIFORM RECRUITING UNIT:
PARTICIPANT CONSENT FOR THE *SHUTTLE RUN* ASSESSMENT

I, undersigned, do hereby acknowledge:

1. My consent to the assessments being supervised by a Qualified Exercise Professional who has been trained to administer these fitness assessment protocols;
2. My understanding that I may ask questions or request further information or explanation about the assessment;
3. My understanding that there exists the possibility of certain changes occurring during and after my performance of the fitness assessments including abnormal blood pressure, fainting, transient light-headedness, leg cramps, muscle strains, nausea, and, in rare instances, heart attacks or heart rhythm disturbances;
4. My obligation to immediately inform the fitness appraiser of any unusual pain, discomfort, fatigue or any other symptoms that I incur during or after the assessment;
5. My understanding that I may stop any further assessments if I so desire and also that the assessment may be terminated by the fitness appraiser upon his/her observation of any symptoms of distress or abnormal response;
6. That if I am over 45 years of age AND not accustomed to regular strenuous (vigorous) exercise, I have been cleared for participation in the fitness assessment by a Qualified Exercise Professional with advanced university specialized training in applied physical activity/exercise sciences or by my physician who completed the clearance form from the ePARmed-X+ at www.eparmedx.com for that purpose;
7. That I do not have two or more of the following coronary risk factors, or If I do, I have received clearance (ePARmed-X+ at www.eparmedx.com) before reporting to participate in the shuttle run; a family history of myocardial infarction or sudden death before 55 years of age; currently smoke cigarettes; have high blood pressure; have diabetes mellitus; have high blood cholesterol or work in a sedentary occupation and am physically inactive;
8. That I have read, understood and completed the Physical Activity Readiness Questionnaire+ (PAR-Q+) and my answers to all questions were "No", or if I answered "Yes" to any question, I was subsequently cleared for participation in the shuttle run by a Qualified Exercise Professional with advanced university specialized training in applied physical activity/exercise sciences or by my physician who completed the referral for that purpose;
9. That I assume all risks associated with normal use of equipment used in the shuttle run.

Name of Participant
(Please Print)

Signature of Participant

Date

Name of Witness
(Please Print)

Signature of Witness

Date

**UNIFORM RECRUITING UNIT:
RELEASE, WAIVER AND INDEMNITY FOR THE SHUTTLE RUN ASSESSMENT**

I, _____ am participating in a physical fitness assessment for the position of:

☐
☐
☐

Police Constable

Special Constable

Other, please specify: _____

I HEREBY FULLY ACCEPT AND ASSUME SUCH RISK and in consideration of undergoing the physical assessment, I for myself, my heirs, executors, administrators, successors and assigns HEREBY RELEASE, WAIVE AND FOREVER DISCHARGE the Region of York, the York Regional Police Service Board and the York Regional Police Service, the York Auxiliary Police Service, the Chief of Police and all their respective agents, officials, servants, contractors, representatives elected and appointed officials, successors and assign OF AND FROM ALL claims, damages, costs, expenses, actions, causes of action, whether in law or equity, in respect of death, injury, loss or damage to my person or property however caused resulting or alleged to result from the physical fitness assessment, whether prior to, during or subsequent to such an assessment AND NOTWITHSTANDING that same may have been contributed to or occasioned by the negligence of any of the aforesaid.

I FURTHER HEREBY UNDERTAKE TO HOLD AND SAVE HARMLESS AND AGREE TO INDEMNITY all of the aforesaid from and against and all liability incurred by any or all of them arising as a result of, or in any way connected with the physical fitness assessment.

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE HAVING READ, UNDERSTOOD AND AGREED TO THE ABOVE RELEASE, WAIVER AND INDEMNITY.

Print Surname, Given

Signature

Date

Witnessed By:

Print Surname, Given

Signature

Date



York Regional Police Performance Declaration

Assessment Being Conducted:

- ☐ Sigma Survey for Police Officers Written Aptitude Test
- ☐ Pre-Background Questionnaire
- ☐ Fitness Testing
- ☐ Interview Assessment
- ☐ Psychological Evaluation Assessment (Psychological Testing and/or Psychological Interview)

1. Candidate Information & Acknowledgement *(please print)*:

Surname:	Given Name(s):	3rd, 6th, 9th digits of SIN / /
-----------------	-----------------------	---

Address – City Only:

Are there any factors which you feel may affect your ability to perform the tests noted above today? If yes, please provide an explanation and complete Section 2 below: ☐ Yes ☐ No

I am aware that the information provided above will be reviewed by the Appraiser and/or a representative of York Regional Police. I understand that the information will be used for the purpose of assessing my qualifications and suitability for employment as a police officer. My signature below acknowledges that I understand, and consent to, this disclosure and use of information.

Signature of Candidate

Date (dd-mm-yyyy)

2. Complete This Section Only if “Yes” Was Answered Above:

☐ After discussing my circumstances as outlined above with the Appraiser or representative of York Regional Police, I have decided to continue with the testing process today. I have made this decision freely and voluntarily after being informed that I may participate in the testing on another date, at my option, without penalty or adverse consequence. I understand that the results of any testing performed today will become part of my application file and will be available to York Regional Police.

☐ After discussing my circumstances with the Appraiser or representative of York Regional Police, I choose not to participate in the testing process today. **Please sign on the day of the session.**

Signature of Candidate

Date (dd-mm-yyyy)

Signature of Appraiser

Date (dd-mm-yyyy)

Appraiser Name (please print)

Date (dd-mm-yyyy)

Note to Candidate: If any factors arise which you feel may affect your performance during testing, please advise the Appraiser or representative of York Regional Police immediately. Personal information obtained through the completion of this form is collected pursuant to section 43 of the **Police Services Act**, for the purpose of assessing qualifications and suitability for employment as a police officer. Information collected may be disclosed for the purpose for which it was obtained, or for a consistent purpose. Questions concerning the collection or disclosure of this information can be directed to your Appraiser or representative of York Regional Police.

PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
1) Has your doctor ever said that you have a heart condition <input type="checkbox"/> OR high blood pressure <input type="checkbox"/> .	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
3) Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise).	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer NO if you had a problem in the past, but it does not limit your current ability to be physically active. PLEASE LIST CONDITION(S) HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your doctor ever said that you should only do medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>



If you answered NO to all of the questions above, you are cleared for physical activity.

Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow Global Physical Activity Guidelines for your age (<https://www.who.int/publications/i/item/9789240015128>).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.



Delay becoming more active if:

- You are currently experiencing a temporary illness, such as a cold or fever. It is best to wait until you feel better.
- You are pregnant. In this case, talk with your health care practitioner, physician, qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
- Your health changes. Answer the questions on Pages 2 and 3 of this document and/or talk to your health care practitioner, physician, or qualified exercise professional before proceeding with any physical activity program.

PAR-Q+

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?

If the above condition(s) is/are present, answer questions 1a-1c

If **NO** ☐ go to question 2

- 1a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐
- 1b. Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)? YES ☐ NO ☐
- 1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months? YES ☐ NO ☐

2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a-2b

If **NO** ☐ go to question 3

- 2a. Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck? YES ☐ NO ☐
- 2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)? YES ☐ NO ☐

3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm

If the above condition(s) is/are present, answer questions 3a-3d

If **NO** ☐ go to question 4

- 3a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐
- 3b. Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction) YES ☐ NO ☐
- 3c. Do you have chronic heart failure? YES ☐ NO ☐
- 3d. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months? YES ☐ NO ☐

4. Do you currently have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b

If **NO** ☐ go to question 5

- 4a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐
- 4b. Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure) YES ☐ NO ☐

5. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes

If the above condition(s) is/are present, answer questions 5a-5e

If **NO** ☐ go to question 6

- 5a. Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies? YES ☐ NO ☐
- 5b. Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness. YES ☐ NO ☐
- 5c. Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet? YES ☐ NO ☐
- 5d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)? YES ☐ NO ☐
- 5e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future? YES ☐ NO ☐

PAR-Q+

6. Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome

If the above condition(s) is/are present, answer questions 6a-6b

If **NO** ☐ go to question 7

6a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

6b. Do you have Down Syndrome **AND** back problems affecting nerves or muscles? YES ☐ NO ☐

7. Do you have a Respiratory Disease? This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure

If the above condition(s) is/are present, answer questions 7a-7d

If **NO** ☐ go to question 8

7a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

7b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy? YES ☐ NO ☐

7c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week? YES ☐ NO ☐

7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? YES ☐ NO ☐

8. Do you have a Spinal Cord Injury? This includes Tetraplegia and Paraplegia

If the above condition(s) is/are present, answer questions 8a-8c

If **NO** ☐ go to question 9

8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? YES ☐ NO ☐

8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)? YES ☐ NO ☐

9. Have you had a Stroke? This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event

If the above condition(s) is/are present, answer questions 9a-9c

If **NO** ☐ go to question 10

9a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

9b. Do you have any impairment in walking or mobility? YES ☐ NO ☐

9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? YES ☐ NO ☐

10. Do you have any other medical condition not listed above or do you have two or more medical conditions?

If you have other medical conditions, answer questions 10a-10c

If **NO** ☐ read the Page 4 recommendations

10a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months? YES ☐ NO ☐

10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)? YES ☐ NO ☐





10c. Do you currently live with two or more medical conditions? YES ☐ NO ☐

**PLEASE LIST YOUR MEDICAL CONDITION(S)
AND ANY RELATED MEDICATIONS HERE:**

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

PAR-Q+




 **If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:**

-  It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
-  You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
-  As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
-  If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

 **If you answered YES to one or more of the follow-up questions about your medical condition:**

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+** at **www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

 **Delay becoming more active if:**

-  You are currently experiencing a temporary illness, such as a cold or fever. It is best to wait until you feel better.
-  You are pregnant. In this case, talk to your health care practitioner, physician, qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmedx.com before becoming more physically active.
-  Your health changes. Talk to your health care practitioner, physician, or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____

DATE _____

SIGNATURE _____

WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact

www.eparmedx.com
Email: eparmedx@gmail.com

Citation for PAR-Q+

Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

Key References

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-S298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.