



Niagara College

“Aging Well at Niagara College”

Stretch & Flex Classes

At Niagara College, our “Stretch & Flex” class for ages 65+ is the perfect blend of fitness and friendship! This lively class is designed specifically for older adults, focusing on *strength training, flexibility, mobility exercises, and gentle stretching*—all essential for promoting overall health and well-being.

Come experience a warm, welcoming environment, where you can meet new friends, share laughs, and feel revitalized. Whether you’re a beginner or simply looking to stay active, you find supportive space that helps you thrive!

Get ready to stretch your body – and your social circle. Don’t miss the fun!!


Sessions run from 10:00am to 11:00am

Cost is \$125 for 10 classes, tax and parking included!

Session #1

 Mondays and Thursdays - June 15 to July 16, 2026

Session #2

 Mondays and Thursdays - July 20 to August 20, 2026
(No class on Aug 3)

Equipment

Optional to bring:

 Yoga mat, 3- 5lbs weights, and your water bottle

✓ Consistent schedule ✓ Friendly group setting ✓ Guided by trained instructor

Stay Active, Stay Strong, Stay Connected

For more information, please email:
fjTesting@niagaracollege.ca

Or call:

Briar 905-401-5589

Sonya 289-440-0161

Please scan for webpage





Niagara College

Registration Form

Stretch & Flex

Last Name:	First Name:
Address:	
City:	
Province:	Postal Code:
Phone:	
Email:	
Licence Plate for Free Parking:	
Are you a Niagara College Graduate: Yes No	

Session # 1	June 15, 2026 – July 16, 2026	<input type="checkbox"/>
Session # 2	Jul 20, 2025 – August 20, 2026	<input type="checkbox"/>

Payment

Credit Card Number:	
Expiry Date:	CVC:

Emergency Contact

Last Name:	First Name:
Relationship:	
Phone:	

Should Niagara College have to cancel any class, you will be notified by email or phone.

Register Online





Niagara College

Consent Form

Stretch & Flex

I acknowledge my consent to undergo an assessment of my physical ability for the:

- *Stretch & Flex Classes*

I understand there are inherent injury and accident risks in engaging in any form of physical activity. As such, I agree to discuss any/all injury or accident-related concerns directly and immediately with the Exercise Professional or qualified Niagara College employee so it can be monitored in an appropriate manner. I also understand it is my right to stop the session if I experience any discomfort or fatigue and should do so immediately upon experiencing any symptoms. I also understand the Exercise Professional may terminate the session if any abnormal signs or responses to exercise are observed. I also hereby absolve Niagara College, as well as all qualified instructors and involved in this program from any responsibility and liability should any form of unforeseen injury or incident occur.

As a client participating in this program, I understand that Niagara College staff may periodically take pictures during various forms of exercise sessions, and I consent to these pictures being taken. These pictures may be used solely for official marketing purposes through a variety of college-based media outlets. I understand that I am not allowed to take any photos or video recordings during the session. This form must be completed, signed by a witness, and submitted to a qualified Niagara College employee prior to any testing being completed.

I acknowledge that I have read and fully understand all the above information. I agree to comply with all the above information as a participating client in this program.

Print Name

Signature

Date

Witness Print Name

Witness Signature

Date



Niagara College

Waiver of Liability, Assumption of Risk & Indemnity Agreement

Stretch & Flex

Herein called “The Activity”, I for myself, my heirs, personal representative or assigns, do hereby release, waive, discharge, and covenant not to sue Niagara College of Ontario, its officers, employees, and agents from liability from any and all claims including the negligence of The Regents of Niagara College of Ontario, its officers, and employees and agents, resulting in personal injury, accidents or illnesses (including death) and property loss arising from, but not limited to, participation in The Activity.

I agree

Assumption of Risks

Participation in The Activity carries with it the potential risks and exposures that cannot be eliminated regardless of the care taken. (Risks may vary from environmental, travel to activity related).

I have read the previous paragraphs and I know, understand, and appreciate these and other risks that are inherent in The Activity. I hereby assert that my participation is voluntary and that I knowingly assume all such risks.

I agree

Indemnification and Hold Harmless

I also agree to INDEMNIFY AND HOLD the Regent of Niagara College, HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney’s fees brought as a result

of my involvement in The Activity and to reimburse them for any such expenses incurred.

I agree

Severability

The undersign further expressly agrees that the foregoing waiver assumption of risks agreement is intended to be as broad and inclusive as it permitted by the law of Canada and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

I agree

Acknowledgment of Understanding

I have read this waiver of liability, assumption of risk, and indemnity agreement fully, and I understand its terms, and understand that I am giving up substantial rights, including my right to sue.

I acknowledge that I am signing the agreement freely and voluntary and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by the law.

I agree

Print Name

Witness Print Name

Signature

Witness Signature

Date

Date



Niagara College

Lifestyle & Medical History Questionnaire

Stretch & Flex

Medical Information

Please check any that apply to you (past or present) and list any important information about your condition:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Irritable bowel syndrome (IBS)
<input type="checkbox"/> Angina	<input type="checkbox"/> Low Blood pressure	<input type="checkbox"/> Menopausal symptoms
<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Pregnant
<input type="checkbox"/> Cancer	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Polycystic ovary syndrome (PCOS)
<input type="checkbox"/> Chronic sinus condition	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Hypo/hyperthyroidism	<input type="checkbox"/> Skin problems
<input type="checkbox"/> COPD	<input type="checkbox"/> Intestinal problems	<input type="checkbox"/> Respiratory disease

Type 1 Diabetes

Type 2 Diabetes

Specify allergies:

Describe any other health condition that is not listed:

Any important information about your condition (if it applies):

Please list any injuries that may interfere with exercising (past or present):

Please list any major surgeries:

Family History

Has anyone in your immediate family been diagnosed with the following?

- Heart Disease If yes, what relation: _____
- High cholesterol If yes, what relation: _____
- High blood pressure If yes, what relation: _____
- Cancer If yes, what relation: _____
- Diabetes If yes, what relation: _____
- Osteoporosis If yes, what relation: _____
- Stroke If yes, what relation: _____

Medications

Are you taking any prescribed medications? If yes, what medications?

Do these interact with any physical activity?

Do you take any over-the-counter medication? If yes, what medication(s)?

Lifestyle and Habits

Do you participate in any structured physical activity? Yes No

If so, please describe:

Minutes of cardiovascular activity & times per week:

At what intensity are the cardiovascular sessions:

Low Moderate High

Strength-training sessions & times per week:

Minutes of flexibility training & times per week:

Minutes of sports per week:

List sport(s):

Accuracy of Information

I certify that the above medical information is correct to my knowledge.

I agree

Print Name

Witness Print Name

Signature

Witness Signature

Date

Date

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+

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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.

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