

# ENROLMENT FORM

Surname .....

Given Names .....

Address .....

.....

Suburb ..... State ..... Postcode.....

Date Of Birth dd/mm/yyyy ..... / ..... / .....

Occupation .....

Telephone  
(home) ..... (mobile) ..... (work) .....

Email .....

Emergency Contact Name .....

Emergency Contact Phone .....

Have you participated in Physical Training before? YES ☐ NO ☐

How did you find out about it? .....

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What is it that you would like to achieve? .....

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# MEDICAL INFORMATION SHEET

Name ..... Male ☐ Female ☐ Date Of Birth ..... / ..... / .....  
dd/mm/yyyy  
Address ..... Telephone .....

## Confidential Fitness Readiness Questionnaire

Many health benefits are associated with regular moderate exercise, and we are glad you have chosen to increase your level of physical activity. For most people an increase in physical activity should not pose any problem or hazard. However, for a small number of adults an increase in physical activity, particularly rigorous physical activity, might be inappropriate. There are also those who should have medical advice in choosing a type of level of activity right for them. The following checklist can help guide you in how to proceed with your new choice, and will guide us in helping you reach the level of activity right for you.

Please complete the form below:

### Have you suffered from any of the following medical conditions?

CHD, Angina, Heart Attack	<input type="checkbox"/> Y	<input type="checkbox"/> N
Heart Murmur, Chest Pains, Palpitations	<input type="checkbox"/> Y	<input type="checkbox"/> N
High Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N
High Blood Cholesterol	<input type="checkbox"/> Y	<input type="checkbox"/> N
Thrombosis Blood Clot	<input type="checkbox"/> Y	<input type="checkbox"/> N
Haemophilia	<input type="checkbox"/> Y	<input type="checkbox"/> N
Stroke	<input type="checkbox"/> Y	<input type="checkbox"/> N
Epilepsy, Fainting or Dizziness	<input type="checkbox"/> Y	<input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y	<input type="checkbox"/> N
Asthma or Respiratory Illness	<input type="checkbox"/> Y	<input type="checkbox"/> N
Osteoporosis (Brittle Bones)	<input type="checkbox"/> Y	<input type="checkbox"/> N
Osteoarthritis	<input type="checkbox"/> Y	<input type="checkbox"/> N
Neck or Back Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N
Hip Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N
Knee Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N
Ankle Pain	<input type="checkbox"/> Y	<input type="checkbox"/> N
Any other Joint Injury (please specify)	<input type="checkbox"/> Y	<input type="checkbox"/> N

### Are you taking the following medication?

Diuretics	<input type="checkbox"/> Y	<input type="checkbox"/> N
Insulin	<input type="checkbox"/> Y	<input type="checkbox"/> N
Diabetic Pill	<input type="checkbox"/> Y	<input type="checkbox"/> N
Epilepsy Medication	<input type="checkbox"/> Y	<input type="checkbox"/> N
Heparin / Warfarin	<input type="checkbox"/> Y	<input type="checkbox"/> N
Anti-Depressants	<input type="checkbox"/> Y	<input type="checkbox"/> N
Other (please specify)	<input type="checkbox"/> Y	<input type="checkbox"/> N

Do you smoke? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N

Have you had a baby in the last 6 months? ☐ Y ☐ N

Any major operations or bone fractures?  
(please give details):

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.....

Do you currently take regular exercise? ☐ Y ☐ N

Are there any other reasons you are aware of that may prevent you from exercising safely? ☐ Y ☐ N

If so, please specify .....

Clients suffering from asthma, diabetes or angina MUST ALWAYS have their medication with them and give it to the instructor before commencing any exercise program.

If you are over the age of 50, you MUST provide us with a medical certificate from your doctor.

I hereby acknowledge that the nature of the exercise I am about to undertake has been fully explained. Whilst I am aware that all care will be taken by the instructors, I do so at my own risk.

Name (Print) .....

Signed ..... Date ..... / ..... / .....