



If you have any questions, please call us on 02392 453 670 / 07800 683 367 or you can email us: info@innovationsfitness.co.uk

The purpose of this form is to ensure that we provide every child and/or adolescent with the highest level of care. For most children, physical activity provides an opportunity for children and adolescents to have fun and promotes the basis for good health and an enhanced quality of life for the future. However there are a small number of children or adolescents who may be at risk when participating in an exercise/physical activity program. We would therefore ask that you read and complete this questionnaire carefully and return to the appropriate staff member. The information contained in this form is confidential and is subject to the laws and regulations contained in the Privacy Laws enacted in December 2001.

**THIS FORM IS CONFIDENTIAL
WHEN COMPLETED**

Child's Information

Child's Name (please print)

Date of Birth

Height (cm)Weight (kg)

Medical History

1. Has a GP or specialist referred your child? (please circle) YES /NO

If you have answered yes to the above please provide GP name
and contact details

2. Is your child currently taking prescribed medication? (please circle) YES/NO

If you have answered yes to the above, please list

3. If your child is taking any medication, please state any side effects experienced as a result of taking this medication.

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4. Is your child registered as disabled? (please circle) YES / NO If yes, please give further details

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5. Has your child had any injuries within the last two years? (please circle) YES / NO If yes, please give further details

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6. Has your child had any physiotherapy or doctor intervention for injury in the last 2 years? (please circle) YES / NO If yes, please give further details

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7. Has your child had any operations in the last 2 years? (please circle) YES / NO If yes, please give further details

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8. In the past 6 months has your child had any muscular pain while exercising? YES/NO

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9. In the last 6 months has your child experienced joint pain in the bones? YES/NO

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10. Has a doctor treated your child for any of the above to wish you have answered 'YES'? YES/NO

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11. Does your child use a 'puffer' or ventilator for asthma? YES/NO

12. Are you aware of any medical reason/condition that may prevent your child from participation in an exercise programme? YES/NO

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13. Is your child currently suffering from or ever suffered from the following? (please tick)

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Stomach/Bowel Trouble |
| <input type="checkbox"/> Serious Accident | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Kidney/Bladder Disorder |
| <input type="checkbox"/> Diabetes/Hypoglycaemia | <input type="checkbox"/> Back/Neck Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Joint Problems | <input type="checkbox"/> Jaundice/Hepatitis |
| <input type="checkbox"/> Severe Stress Reaction | <input type="checkbox"/> Hernia or Rupture | <input type="checkbox"/> Skin Problems/Allergies |
| <input type="checkbox"/> Surgical Operations | <input type="checkbox"/> Hearing/Sight Problems | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> ADHD | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Heat stroke/heat related illness |
| <input type="checkbox"/> Downs Syndrome | <input type="checkbox"/> Hypermobility | <input type="checkbox"/> Intellectual Impairment |
| <input type="checkbox"/> Coughing during or after exercise | <input type="checkbox"/> Increased bleeding tendency/ haemophilia | |

Declaration

The information that I have provided is, to the best of my knowledge both true and accurate. Innovations Fitness recognises that physical activities which they offer may, in some circumstances create a risk of personal injury. Innovations Fitness goes to reasonable lengths to limit these risks as far as possible. Participants in these activities should be aware of and accept these risks and be responsible for their own actions and involvement. Parents are responsible for their child's safety at all times throughout the session.

Name of child.....

Full Name (please print)

Address of parent or guardian

Contact number of parent or guardian

Parent or guardian

Signature.....Date.....

