

CHILDS NAME:

CHILD’S DATE OF BIRTH:

CHILD’S GENDER (please circle as appropriate): M F OTHER

|  |  |  |
| --- | --- | --- |
| DO ANY OF THE FOLLOWING APPLY TO YOUR CHILD? *If yes please provide details in the notes section on next page.* | YES | NO |
| 1. Diagnosed medical condition such as: diabetes, heart disease, stroke, high blood pressure, cystic fibrosis, asthma, cerebral palsy, lung problems or other chronic conditions. |  |  |
| 2. Experience any abnormal episodes i.e. seizures, fainting, heat-stroke. |  |  |
| 3. Diagnosed psychological/behavioural disorders related to exercise |  |  |
| 4. Muscle, bone or joint problems |  |  |
| 5. Neuromuscular difficulties such as brain or spinal injuries. |  |  |
| 6. Sensory issues such as vision, hearing, speech, balance. |  |  |
| 7. AllergiesDoes your child carry an Epi Pen? |  |  |
| 8. Other medical condition or reason which might prevent the child from participating in an exercise program. |  |  |
| 9. Any Medications that the child takes that we should be aware of (in relation to exercise, or side effects that may effect or prevent child from taking part in exercise). |  |  |



Notes:

I believe that to the best of my knowledge, all the information I have supplied within this tool is correct.

Signature of parent/guardian:

Date:

I consent for my child’s image to be used for advertising purposes

Signature of parent/guardian:

Date: