

Medical Consent Form

Medical History:

Has anyone in your family under 60 ever suffered from heart disease, stroke, high cholesterol or sudden death	Y/N
Are you a female over 45 and not used to regular exercise?	Y/N
Are you on any prescribed medication?	Y/N
Have you given birth within the last 6 weeks?	Y/N
Are you pregnant?	
Do you suffer from any infectious diseases?	
Have you been hospitalised recently?	

Do you suffer or have ever suffered from the following:

ME	Y/N
Glandular Fever	Y/N
Stroke	Y/N
Heart Murmur	Y/N
Dizziness or Fainting	Y/N
Palpitations	Y/N
Liver or Kidney Condition	Y/N
Raised Cholesterol/Triglycerides	Y/N
High Blood Pressure (> 120+age/95)	Y/N
Stomach Ulcer	Y/N
A miscarriage in the past 6 months	Y/N
MS	Y/N
Gout	Y/N
Any heart condition	Y/N
Rheumatic Fever	Y/N
Diabetes	Y/N
Epilepsy	Y/N
Hernia	Y/N

Have you ever or do you suffer from:

Arthritis	Y/N
Asthma	Y/N
Cramps	Y/N
Muscular Pain	Y/N

Any Pain or injuries in the following areas:

Neck	Y/N
Back	Y/N
Knees	Y/N
Ankles	Y/N
Shoulders	Y/N
Wrists	Y/N

If you have answered YES to any of the above, please provide details of the medication, condition and the approximate date cleared.....

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Declaration

I recognise that the instructor is not able to provide me with medical advice with regard to my medical fitness and that this information is used as a guideline to the limitations of my ability to exercise. I have answered the questions above to the best of my ability and I am aware that any physical activity can be hazardous and that there is a risk involved.

Name:

Signature:

Date:

Doctors name:

Surgery:

Emergency Contact Name:

Number: