EXERCISE DISCLAIMERS

NAME-_____

D.O.B-_____

ADDRESS-

_____

_____

TELEPHONE NUMBER -_____

EMERGENCY CONTACT DETAILS-

_____

_____

MEDICAL QUESTIONS

PLEASE CIRCLE-

Do you have high or low blood pressure?

Yes No

Has your doctor ever said you have a heart condition?
Yes No

Do you feel pain in your chest when you do physical activity?
Yes No

Do you lose your balance because of dizziness or do you ever lose consciousness?
Yes No

Do you have a bone or joint problem that could be made worse by a change in your physical activity?
Yes No

Is your doctor currently prescribing drugs for blood pressure or heart condition or any medication that may affect you when taking part in physical exertion?
Yes No

Are you pregnant?
Yes No

Do you know of any other reason which may affect your ability to take part in physical activity?

Yes No

If yes please state why:

PLEASE SIGN-