

AJ Connect medical form

Applicant's details

Surname: _____ First name: _____

Membership No: _____

PLEASE NOTE: The following medical information is required to ensure that the appropriate provisions can be made for your welfare whilst you are participating in our AJ Connect course. If you suffer from any chronic or recurrent ailment or physical restriction, it must be disclosed in as much detail as possible. Add additional pages if required.

1. Has a GP or Specialist referred your child?

Yes No

Details: _____

2. Does your child take any medication?

Yes No

Details: _____

Heart, lung and other systems

3. Does your child have any of the following?

Diabetes: Yes No

Heart condition: Yes No

Cystic fibrosis Yes No

High cholesterol: Yes No

Breathing difficulties: Yes No

Unexplained coughing: Yes No

If yes to any of the above, please give details: _____

Brain and muscle system

4. Does your child have difficulties with any of the following?

Vision: Yes No

Hearing: Yes No

Speech/language: Yes No

Gross/fine motor skills: Yes No

Poor balance/instability Yes No

Sleep apnoea Yes No

If yes to any of the above, please give details: _____

5. Has your child ever experienced a brain or spinal injury?

Yes No

Details: _____

Muscle and bone system

6. In the last six months, has your child had any muscular pain while exercising?

Yes No

Details: _____

7. Has a doctor treated this pain?

Yes No

Details: _____

8. Has your child broken any bones or suffered injury to their bones in the last 12 months?

Yes No

Details: _____

Special conditions

9. Does your child have any of the following?

Cerebral palsy:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
ADHD:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Down syndrome:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hyper mobility	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Obesity:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Intellectual impairment:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Allergies	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If yes to any of the above, please give details:

10. Is your child's blood pressure:

High Low Normal

Details: _____

11. Is your child allergic to food, medications, pollens or other allergens or specific environments?

Yes No

Details: _____

Informed consent

I hereby acknowledge that:

- The information provided above regarding my child's health is correct to the best of my knowledge
- I will inform you immediately if there are any changes to the information provided above
- I give permission for my child to commence your physical activity program.

Parent/ Guardian signature: _____ Date: _____

Print name: _____

Thank you for taking the time to out this form in its entirety. The information that you provide will assist us to ensure that you have a positive and enjoyable experience.

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