

Health Screening Questionnaire and Informed Consent CONFIDENTIAL

CLASS VENUE AND TIME:	
Name:	
Address:	
Date of birth:	
Occupation:	
Contact number	
Email address	
Emergency contact/next of kin	
MEDICAL INFORMATION:	
Do you have/have you ever had any of the follo	owing? Please circle:
High//low blood pressure	Neck or back pain
Asthma	Other joint pain
Menstrual disorder/pain	Allergies
Diabetes	Epilepsy
Osteoporosis	Stroke
Chest pain/angina	Other illness/disability
Are you pregnant or have you been pregnant in	the last 3 months?
Are you presently taking medication?	
Is there anything else that may stop you from e	exercising safely? (eg. cancer, mental illness, thyroid
problems, kidney disease, liver disease, arthriti	s etc)
Please give dates/details:	

If you have answered yes to any of the above, I recommend you seek medical approval prior to starting a session.



INFORMED CONSENT

I accept that exercise carries some risk to the musculoskeletal system (sprains and strains) and the cardio respiratory system (dizziness, discomfort in breathing etc). I hereby certify that I know of no medical problem (other than any mentioned earlier) that would increase my risk of illness or injury as a result of exercising.

I therefore accept that I am personally responsible for my actions, and waive Tanya Buck of all responsibility should I incur any illness or injury whilst under the guidance and supervision of Tanya Buck.

Sianat	tureDateDate
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Cours	se/Class Enrolment
-	I would like to enrol for a week course beginning on (date) at (time)
-	I have paid the full course fee of \pounds by cheque/cash/bank transfer to the Instructor
Please	e make payment by cash, bank transfer or Paypal. Any cheques should be made payable to Tanya
Buck.	Please complete and return this form to me.

If you have any queries, please contact Tanya on 07939 124916 or email info@tanyabuck.co.uk