

Children's Health Screening Form

Childs First Name	Childs Surname
Date of Birth	Age

Address	Emergency Contact
	Name: _____ No. _____
	Relationship to child: _____

Does your child have or ever experienced the following	Yes	No
1. High blood pressure		
2. Elevated blood cholesterol		
3. Diabetes		
4. Childhood epilepsy		
5. Dizziness or fainting		
6. A bone, joint or muscular problem or arthritis		
7. Asthma or respiratory problems		
8. Any sustained injuries or illnesses		
9. Any allergies		
10. Is your child taking any medication		
11. Has your doctor ever advised your child not to exercise		
12. Does your child have ADHD		
13. Is there any reason not mentioned above why any type of physical activity may not be suitable for your child		

If you answered yes to any of the above please give details here:

Declaration

In signing this form, I the parent/guardian of the afore mentioned child, affirm that I have read this form in its entirety and I have answered the questions accurately and to the best of my knowledge

I understand that my child is responsible for monitoring him or herself throughout the activity and should any unusual symptoms occur, they would cease participation and inform the instructor.

In the event that a medical clearance must be obtained prior to my child's participation in any activity session, I agree to contact my GP and obtain permission prior to commencement of the activity and that this permission be given to the instructor.

Parent / Guardian Signature: _____

Print Name: _____ **Date:** _____

Photographs / Videos may be taken during the program for promotional reasons.

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1.0	Aidan McCarthy	25.08.2013	1