Medical Questionnaire

Please read the following questions carefully and answer as accurately as possible. The data you provide will be safeguarded in accordance with the UK Data Protection Act.

Name: …… Date of Birth: ……..

Do you have or have you had any of the following? Please circle Yes or No

1. Frequent or severe headaches. YES / NO
2. Dizziness or fainting spells. YES / NO
3. Asthma or lung disease. YES / NO
4. Heart or vascular problems. YES / NO
5. High or low blood pressure. YES / NO
6. Epilepsy or seizures. YES / NO
7. Diabetes. YES / NO
8. Stroke. YES / NO
9. Muscular disorders or joint problems. YES / NO
10. Chest pains. YES / NO
11. Back Complaint. YES / NO
12. Lower limb or joint problems. YES / NO

If you have answered yes to any of the above please give details.

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Please give details of any medication you take regularly.

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Do you have any known allergies? ……

Any other information you feel we should know: ……

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Emergency Contact Details

Name…….. Contact Number……..

I declare that the details I have given are to the best of my knowledge correct and that I am not aware of any reason why I should not participate in any of the activities on offer.

Signed…….. Date……..

Parent/Guardian Signature (if under 18) ……