**Boot Camp Registration Form**

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| **Name:**  | **DOB:** |
| **Address:** | **Mobile:** |
| **Post Code:** | **Email:** |
| **GP:** | **Emergency Contact****Name:****Relationship:****Mobile:** |
| **Allergies:** | **Medication:** |

Our goal is to safeguard the privacy, confidentiality, integrity, availability and quality of the information we manage. We do this because it’s what you trust us to do with your most sensitive information, not just because it’s required by law. 3RPhysiotherapy will hold information about you. Only members of 3RPhysiotherapy have access to individual data on a need-to-know basis. We communicate consent in writing and signature for 2 reasons. Readiness to partake in exercise and consent to contact you through email, sms and phone calls.

All processes and policies are available upon request.

By signing this form, you are acknowledging that you understand the nature of the information that will be taken by 3RPhysiotherapy. Please be assured that this information will only be passed to 3RPhysiotherapy management with your consent.

I agree to my email address, phone number and address being used by 3RPhysiotherapy for client contact.

I agree to my email address being used with 3RPhysiotherapy for offers and new information. (We will not share information for marketing purposes outside of 3RPhysiotherapy).

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Activity Readiness Questionnaire**

1. Do you have a bone or joint problem, such as arthritis that has been aggravated by exercise or might be made worse with exercise? YES / NO
2. Do you have high blood pressure? YES / NO
3. Do you have low blood pressure? YES / NO
4. Do you have Diabetes Mellitus or any other metabolic disease? YES / NO
5. Has your doctor ever said you have raised cholesterol? YES / NO
6. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? YES / NO
7. Have you ever felt pain in your chest when you do physical exercise? YES / NO
8. Is your doctor currently prescribing you drugs or medication? YES / NO
9. Have you ever suffered from unusual shortness of breath at rest or with mild exertion? YES / NO
10. Do you often feel faint, have spells of severe dizziness or have lost consciousness? YES / NO
11. Are you, or is there any possibility that you might be pregnant? YES / NO
12. Do you know of any other reason why you should not participate in a physical activity programme? YES / NO

If you answered YES to any of the questions above please give details:

If you answered YES to one or more questions please seek medical guidance as to your suitability for engaging in an unrestricted physical activity fitness session and sign the additional note below.

If you answered NO to all questions please sign the form below.

**Assumption of Risk**

I hereby state that I have read, understood and answered honestly the questions above. I also state that I wish to participate in activities, which include aerobic exercise, resistance exercise and stretching. I realise that my participation in these activities involves the risk of injury and even the possibility of death.

**Clients Name: Clients Signature:**

**Date:**

***If under 16 years old***

**Parent/Guardian’s Parent/Guardian’s**

**Name: Signature:**

**Date:**

**Additional Note**: I have taken medical advice and my doctor has agreed that I should exercise.

**Clients Signature: Date:**