kate wood fitness

Pre-Exercise Screening Questionnaire
(Children Under 16 years of Age)

Please arrive 5 minutes earlier to your initial session with this completed questionnaire.

If you have any concerns, please contact Kate (via email, phone or text). Thank you.

The purpose of this pre-exercise questionnaire is to ensure we provide every child and/or adolescent with the highest level of care. For most children, physical activity provides the opportunity to have fun and promotes the basis for good health and enhanced quality of life for the future. However, there are a small number of children and/or adolescents who may be at risk when participating in an exercise/physical activity program. We ask that you read and complete this questionnaire carefully before undertaking any participation with Kate Wood Fitness. The information contained in this form is confidential and is subject to the laws and regulations contained in the privacy laws enacted in December 2011.

Personal Details

Name: DOB: M/F:

How old was your child as at 1st January this year:

Name/s or parent/s or guardian/s:

Home Address:

Mobile Phone:

Has a GP or specialist referred your child?

Doctors name: Contact Ph:

If there is an emergency, please specify the person who should be contacted and their emergency phone number.

Name: Contact Ph:

Please note: In case of a medical emergency, an ambulance may be used to transport your child to the nearest medical treatment service.

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Heart/Lung – Other Systems

1. Does your child have, or has your child had:

- ☐ A heart condition
  (please specify): _____
- ☐ Cystic Fibrosis
- ☐ Diabetes (Type I or Type II – please specify)
- ☐ High Blood Pressure (specify last episode and reading)
- ☐ High Cholesterol
- ☐ Unexplained coughing during or after exercise
- ☐ Breathing problems or Shortness of Breath (e.g. Asthma, Emphysema)

2. Does your child experience or has your child ever experienced:

- ☐ Epilepsy or Seizures/convulsions
  If yes, is at rest or during exercise?
- ☐ Fainting
- ☐ Dizzy spells
- ☐ Heat stroke/heat related illness
- ☐ Increased bleeding tendency/haemophilia
- ☐ Other
  (please specify):

3. Does your child have, or has your child had, an eating disorder:

- ☐ Yes
- ☐ No

4. Does your child take any medications for (please name):

- ☐ Heart problem
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Attention Deficient Disorder (ADD)
- ☐ Asthma/breathing problems
- ☐ Allergies
- ☐ Blood pressure
- ☐ Other (please specify):

4.1 If your child is taking any medication, please state if there are any side effects experienced as a result of taking this medication:

Muscle-Bone System

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

- ☐ Yes
- ☐ No

If yes, please explain and indicate where the pain has occurred?

1.1 Has a doctor or therapist treated this pain?

- ☐ Yes
- ☐ No

2. In the last six months has your child experienced joint pain or pain in the bones?

- ☐ Yes
- ☐ No

If yes, please explain and indicate where the pain has occurred?

2.1 Has this joint pain, or pain in the bone been treated by a doctor or specialist?

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

If yes, please explain where and how the break/injury occurred?

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Brain – Muscle System

1. Does your child have, or has your child had difficulty/problems with any of the following:

- ☐ Vision
- ☐ Hearing
- ☐ Speech/language
- ☐ Motor sensory skills
- ☐ Poor balance/instability
- ☐ Sleep apnoea

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

- ☐ Yes
- ☐ No

Special Conditions

1. Does your child use a 'puffer' or 'ventilator' for asthma?

☐ Yes ☐ No

2. Does your child self-administer insulin for diabetes?

☐ Yes ☐ No

3. Does your child have any chronic disability or chronic illness?

☐ Yes ☐ No

If yes, please indicate the condition:

- ☐ Cerebral Palsy
- ☐ ADHD
- ☐ Downs Syndrome
- ☐ Hypermobility
- ☐ Obesity
- ☐ Intellectual Impairment
- ☐ Other (please specify):

_____

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

☐ Yes ☐ No

If yes, please explain what causes have been identified with this/these allergy/ies:

_____

_____

5. Does your child have a prescription for an Epipen?

☐ Yes ☐ No

6. Does your child follow a special diet?

☐ Yes ☐ No

7. Has your child ever been diagnosed with a nutritional deficiency (such as non-iron deficiency)?

☐ Yes ☐ No

If yes, please specify the nutritional deficiency?

_____

General Health

1. Has your child had surgery in the previous 12 months?

☐ Yes ☐ No

If yes, please specify:

_____

2. Are you aware of any medical reason/condition which might prevent your child from participating in an exercise program?

☐ Yes ☐ No

If yes, please explain:

_____

3. What are your child's favourite hobbies or interests?

_____

4. Does your child aspire to compete any upcoming events? Please state:

_____

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Informed Consent

I hereby acknowledge that:

- ☐ The information provided above regarding my child's health is, to the best of my knowledge, correct.
- ☐ I will inform you immediately if there are any changes to the information provided above whilst my child is participating in a Kate Wood Fitness Training Program.
- ☐ I give permission for my child to commence your physical activity training program.
- ☐ I understand my child participates entirely at his/her own risk, and must exercise due care to ensure his/her personal health and safety, and that of others.
- ☐ I have explained to my child that they need to listen and follow any directions or advice affecting their safety and that of others, given to me by Kate Wood Fitness Trainers.

Parent/Guardian signature: _____ Date: _____

Kate Wood Fitness
(Optional)
How did you hear about Kate Wood Fitness?

- ☐ Word of Mouth
- ☐ Mail Drop/Brochure
- ☐ Google Search
- ☐ Social Media
- ☐ Referred by a friend

please specify who): _____

Administration Only:
Exercise Physiologist Notes:

- ☐ Child/Adolescent has no risk factors >> cleared to participate in Kate Wood Fitness Physical Activity Training Program
- ☐ Child/Adolescent has one or more Heart-Lung Other Risks >> refer to Medical Practitioner
- ☐ Child/Adolescent has one risks from Muscle-Bone and or Brain-Muscle systems or Special Conditions and General Health Sections >> possibly refer to Medical Practitioner or appropriate Allied Health Professional**

**Name and Title of AHP child/adolescent is referred to:

_____

Signatures

Parent/Guardian signature: _____ Date: _____

Exercise Physiologist: _____ Date: _____