Sports Med. Ireland

Name:_____ Date:_____

Address:_____

Phone – Home:_____ Mobile:_____ Work:_____

Guardian/Parent Email Address:_____

Date of Birth:_____ Weight:_____ Height:_____ Level of activity: Low Moderate High

Sport (Optimist Sailing): _ Fleet:_____ Rank:_____

Doctor:_____ Phone:_____

In case of emergency contact:_____ Relation:_____

Address:_____ Phone:_____

Text Message/Occasional Marketing Email Consent: **please mark** - Yes / No - we will remind you of your next appointment by sending you a text message to your mobile phone and occasionally send email promotions - Yes / No ☐

Skip this section(Part 1) unless you have an Injury and go to Part 2

Part 1: Symptoms / Current Problem

1. Do you have a particular injury/problem needing treatment at the moment?

   _____

2. What is this current problem?

_____

3. When and How did this happen?

_____

4. Have you had any previous treatments for this same problem?

_____

5. Do you suffer from swollen ankles (due to circulation problems or metabolic condition)?

_____

6. Has your doctor ever said you have heart trouble, heart palpitation, coronary disease, or high blood pressure? _____

7. Do you frequently experience pain or discomfort in the chest or heart area?

_____

8. Do you suffer from shortness of breath at rest or upon mild exertion?

_____

9. Do you suffer dizziness or fainting?

_____

10. Do you have any difficulty breathing?

_____

NB - If "yes" is the answer to any of the above you must make us aware in advance and if relevant your Doctor may need to provide a medical clearance form prior to commencing exercise

Part 2 Risk Factors

1. Has a doctor ever diagnosed you as having high blood pressure (>160/90), or are you on blood pressure medication?____ BP Measurement- Right arm_____ Left arm _____ Average _____

2. Your cholesterol is _____mg/dL.(<6 months ago.) Is the value > 240mg/dL.?

_____

4. Do you suffer from diabetes? _____

5. Has anyone in your immediate family suffered from coronary or atherosclerotic disease prior to the age of 55 years? _

6. ***NB - If "yes" is the answer to any of the above you must make us aware in advance and if relevant your Doctor may need to provide a medical clearance form prior to commencing exercise***

Medication/ Limitations/ Past medical history

1. Name any medication(s) (and doses) you are currently taking:_____

2. For what condition(s)?

_____

3. Have you any allergies?_____ If yes what are they?_____

4. Do you have any physical limitations /illness/medical history that would limit your ability to exercise?

_____

5. If yes, what are they?_____

6. List dates/outcomes of any past surgeries, x-rays, abnormal test results, hospitalisations and/or treatments:_____

__

7. Do you have Medical Insurance? Yes No Insurer's Name:_____

I pledge that all the information which I have provided in this form is accurate, to the best of my knowledge, and that I have not willingly excluded any important medical information which could have any bearing on my ability to safely engage in exercise testing and exercise participation. I am aware that a no show or cancellation with less than 24hrs notice will result in a cancellation fee being charged:

Signature of Participant:_____
Date:_____

Witness:_____
Date:_____

(If participant under 18 years of age a parent/guardian must sign form)

Parent/ Guardian:_____
Date:_____

Testing/ Exercise Objective: I understand that the tests and/or exercises that are about to be administered to me are for the purpose of determining and/or developing my physical fitness status, including flexibility, muscular strength, muscular endurance, muscular power and agility.

Explanation of Procedures: I understand that the tests and/or exercises, which I will undergo, may be performed indoors or outdoors, in water or on dry land. The tests and or exercises are designed to, and will, increase the demands on the heart, lungs, vascular, muscular and skeletal systems. Various static and dynamic exercise modalities may be employed to test or stimulate the multiple systems of the body. These include, but are not limited to: running, walking, water exercises, callisthenics, free weights, resistive training machines, rubber bands, medicine balls training etc.

Description of potential risks: I understand that there exists the possibility that certain abnormal changes may occur during the testing and/or my exercise participation. These changes could include abnormal heartbeats, abnormal blood pressure response, various muscle and joint injuries, and in rare instances heart attack and death. Professional care throughout the entire testing and /or exercising session should provide appropriate precautions against such abnormal responses. However, these risks are still present.

Benefits to be exercised: I understand that the result of any test administered to me will aid in: determining my current physical fitness/performance status, determining potential health hazards and designing an appropriate exercise program. The exercises, which I will engage in, are designed to enhance the fitness parameters, measured by the exercise test, namely flexibility, muscular strength, muscular endurance, muscular power and agility.

I have read the foregoing information and understand it. Questions concerning all procedures have been answered to my satisfaction. I also understand that I am free to deny answering any questions during the test/exercise sessions. I have also been informed that the information derived from these tests is confidential and will not be disclosed to anyone other that my doctor or others who are involved in my care or exercise prescription without my permission.

Signature of Participant:_____
Date:_____

Witness:_____
Date:_____
(If participant under 18 years of age a parent/guardian must sign form)

Parent/ Guardian:_____ Date:_____