

DSHOOPS.CO.UK BOOKING FORM

Please take a few minutes to answer the following questions, indicating (Y) for YES or (N) for NO. If unsure about your answers to any of the questions, please discuss them with your instructor. All data obtained through this form will remain strictly confidential.

CLIENT INFORMATION

Full name:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss
		<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.
Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Email address:	
Address:		Mobile:	Home phone no.:
Person to contact in case of emergency:	Name:	Phone number:	

How did you hear about us:
(word of mouth, advertisement, event...)

CLASS OR COURSE YOU WOULD LIKE TO ATTEND:

(date & venue)

General Health

<p>Y/N Has anyone in your family under 60 suffered from Heart Disease, Stroke, High Cholesterol or Sudden Death?</p> <p>Y/N Are you male over 35 or female over 45 and NOT used to regular vigorous exercise?</p> <p>Y/N Are you on a prescribed medication?</p> <p>Y/N Have you given birth within the last 6 weeks?</p> <p>Y/N Do you suffer from infectious diseases?</p> <p>Y/N Have you been hospitalized recently?</p> <p>Y/N Are you pregnant?</p>	<p>Do You suffer from or have suffered from any of the following?</p> <p>Y/N Diabetes</p> <p>Y/N ME</p> <p>Y/N Heart Murmur/ any heart condition</p> <p>Y/N Glandular Fever</p> <p>Y/N Stroke</p> <p>Y/N Dizziness or Fainting</p> <p>Y/N Palpitations</p> <p>Y/N Liver or Kidney Condition</p> <p>Y/N Raised Cholesterol/Triglycerides</p>	<p>Y/N Hernia</p> <p>Y/N High Blood Pressure</p> <p>Y/N MS</p> <p>Y/N Stomach or Duodenal Ulcer</p> <p>Y/N A miscarriage in the past 6 months</p> <p>Y/N Gout</p> <p>Y/N Diabetes</p> <p>Y/N Epilepsy</p>
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If You have indicated (Y) Yes you may need to take this form to your physician and ask for clearance to exercise before starting any hoopdance programme.

CONDITION CLEARED

Physician Sign: _____
Date: _____

Have You ever or do You suffer from: (please underline)

Arthritis **Asthma** **Cramps** **Muscular Pain**

Any pain or major injuries particularly in the following areas?

Neck **Back** **Knees** **Ankles** **Shoulders** **Wrists**

Do you smoke? Y/N

Are there any other conditions which may cause your hoopdance programme to be modified?

PLEASE READ THE FOLLOWING CAREFULLY:

Photo Release: I hereby give Beata Varga (dshoops.co.uk) permission to use film, video and/or photographs of the above mentioned minor or adult for lawful promotional or informational purposes . Yes/No

Statement: I recognize that the instructor is not able to provide me with medical advice with regard to my medical fitness and that this information is used as a guideline to the limitations of my ability to exercise. I have answered the questions to the best of my ability and understand the advice above. I am aware that any physical activity can be hazardous and that there is risk involved.

Signed (by parent or guardian if under 18): _____

Date: _____