ADOLESCENT CLIENT DETAILS & CLEARANCE FORM

The information obtained will be treated as confidential and will not be released or revealed to any person without your written consent. The information obtained may be used for statistical or scientific purpose with your right of privacy retained.

PERSONAL INFORMATION

Name: ___________________________________ Age: _________DOB: ____________________________________

Address: ____

Gender: __________________________________

EMERGENCY CONTACT

Name: ____ Relationship: ______________________

Phone: ____________________________ Email: ____

DROP OFF/PICK UP INFORMATION

I, ____________________________ hereby give permission for Chronic Care Australia and The Exercise Therapist to release my child to the following person/s:

Name: ______________________Relationship: _____________________Contact:_______________________________
Name: ______________________Relationship: _____________________Contact: _______________________________
Name: ______________________Relationship: _____________________Contact: _______________________________
Name: ______________________Relationship: _____________________Contact:_______________________________

IS YOUR CHILD SEEING ANY ALLIED HEALTH PROVIDERS:

- Psychologist ☐ Name: ____
- Occupational Therapist ☐ Name: ____
- Physiotherapist ☐ Name: ____
- Dietitian ☐ Name: ____

Other? Please specify:

CURRENT MEDICATIONS/SUPPLEMENTS

Please list any medications or supplements your child is currently taking or prescribed:

____

____

CURRENT OR PRE-EXISTING CONDITIONS OR INJURIES

If your child has experienced any conditions/injuries that impact their ability to exercise, please specify below:

____

____

ESSA PRE-EXERCISE & CURRENT HEALTH SCREENING

Does your child have, or previously had:

• A heart condition?	Yes	No
• A close relative who has died suddenly from a heart condition before the age of 50?	Yes	No
• Uncontrolled epilepsy or seizures/convulsions?	Yes	No
• Unexplained chest pain at rest or during physical activity	Yes	No
• Fainting or dizzy spells with physical activity/exercise?	Yes	No
• Diabetes? Please specify type	Yes	No

• Asthma attack requiring immediate medical attention at any time over the last 12 months?	Yes	No
• Anaphylactic reactions? Please specify	Yes	No
• Surgery in the last month? Please specify	Yes	No
• Muscular/Joint/Ligament/Tendon injury? Please specify	Yes	No
• Mental illness? Please specify	Yes	No
• Age-related conditions and or injuries?	Yes	No
• Any other conditions that may require consideration for your child to exercise?	Yes	No

CLEARANCE FORM

RISK WARNING ACKNOWLEDGMENT AND ASSUMPTION OF RISK RELEASE & INDEMNITY

WARNING: THIS IS AN IMPORTANT DOCUMENT WHICH AFFECTS YOUR LEGAL RIGHTS AND OBLIGATIONS. READ IT CAREFULLY AND DO NOT SIGN IT UNLESS YOU ARE SATISFIED THAT YOU UNDERSTAND IT. IF YOU HAVE ANY QUESTIONS PLEASE ASK OUR REPRESENTATIVE.

RECREATIONAL ACTIVITY PROVIDER: ELITE HEALTH MANAGEMENT TRADING AS THE EXERCISE THERAPIST

PARTICIPANTS NAME: ______________________________ AGE: ____________

**(If under 18 years, parent/guardian to also sign)

WARNING AND ACKNOWLEDGMENT OF RISKS, INJURY AND OBLIGATIONS

I Acknowledge that the activity I am to undertake is a dangerous recreational activity that may involve a significant risk of physical harm (the "activity") and that by participating in it I am exposed to certain risks. **I further acknowledge that I am not required to engage in the activity.**

RELEASE AND INDEMNITY TO THE RECREATIONAL ACTIVITY PROVIDER

IN CONSIDERATION of my payment for participating in the activity (and except to the extent that the same may be precluded by statute) **I AGREE TO RELEASE AND INDEMNIFY** the Recreational Activity Provider as follows:

1. I participate in the activity at my own risk and responsibility.
2. I release, indemnify and hold harmless the Recreational Activity Provider, its servants and agents, from and against all and any actions or claims which may be made by me or on my behalf or by other parties for or in respect of or arising out of any injury, loss, damage or death caused to me or my property in any way whatsoever or any liability that results from the breach of an express or implied warranty that the recreational services or activity will be rendered with reasonable care or skill.

BEFORE SIGNING THIS DOCUMENT:

- **I have read and understood it and know that it affects my legal rights**
- **The above represents and warrants to Elite Health Management PTY LTD (trading as The Exercise Therapist) that I have disclosed all details or any medical condition I have and of all recent medical treatment received by me**
- **I have read and understood all Terms and Conditions. We do not provide refunds on Care Clinic programs, or The Exercise Therapist services (this includes private consultations and group training programs), however, will allow discussion and review of specific circumstances with Director of The Exercise Therapist, Katie Stewart.**

I would like to receive important clinic communications, research articles and promotions ☐ Yes ☐ No

Parent/Guardian Name:		Sign:		Date:	
AEP Name:		Sign:		Date:	