Rebound Therapy Medical Clearance

five dock leisure centre

Member Number:_____

Name: _____ D.O.B:_____ Male/Female

Address: _____ Suburb: _____ P/code: _____

Phone (m):_____Email: _____

Emergency Contact Name: _____ Emergency Contact Number: _____

How did you hear about us?:_____

What is your fitness goal?: _____

CONDITION	**YES**	**NO**
Has anyone in your family under 60 suffered heart disease, stroke, raised cholesterol or sudden death?		
Are you either Male and over 35 or Female and over 45 and not used to regular exercise?		
Have you been hospitalized recently?		
Do you have any Heart Condition?		
Are you pregnant?		
Do you have High Blood Pressure (greater than 149/90)?		
Do you ever have Palpitations or pains in the chest?		
Do you have high Cholesterol / Triglycerides?		
Do you have, or have you ever had (please circle) Gout – Stroke – Diabetes – Epilepsy – Hernia - Glandular Fever - Rheumatic Fever – Dizziness - Fainting Liver or Kidney condition – Stomach or Duodenal Ulcer		
Have you been diagnosed with atlantoaxial instability (down syndrome participants)?		
Do you have any major pain or injuries to your neck, back, knees or ankles?		
Are there any conditions that would require you to modify your exercise program?		
Are you taking any medication?		

If you have answered YES to any of the above, please provide details of condition, recommended exercise modifications and medication including any contraindications to exercise:

If any of the above conditions have been experienced, please either obtain physicians clearance to exercise prior to commencement, or sign below if the condition has already been cleared by your doctor.
It is recommended that males over 35 and females over 45 should have a medical assessment including an ECG and cholesterol/lipid count. Should you suffer injury, illness or a condition in the future, please complete this form again. I acknowledge that I will choose my exercise intensity based on my personal level of health and fitness and I am choosing to do so at my own risk.

SIGNATURE: _____ DATE: _____

OFFICE USE ONLY:
Staff Name:_____
Type of pass issued (please circle: Casual - One Day - 7Day
Toured? (please circle): Yes - No

Getting the most out of our gymnasts.

five dock leisure centre

* Denotes must complete

***Gymnast Name:**

***Gymnast Age:**

* **Class Day/Time:** ***Tuesdays 12:00 – 12:45pm***

***What way does the gymnast best learn?** E.g. My child has a learning delay and engages best through clear and concise sentences with a visual demonstration of the task.

***Does the gymnast use alternative methods of communication** (please list)**?** E.g. Communication Board, Key Word Sign, Lip Reading etc .

***Is there any information about the gymnast that the coach should be made aware of?** E.g. Previous injury, weakness on a particular side of the body etc

Are there any behaviour management strategies that the coach needs to be made aware of?

Trigger	Warning signs	Behaviour	How to avoid	Calming techniques
E.g. Loud noises	- Covering ears - Closing eyes - Lying on the ground	- Screaming - Running away - Not listening	- Ask people around to lower their volume - Use ear plugs - Try to move the child's attention to a specific class	- Speak calmly and softly - Ask questions about trains and aeroplanes

Does the gymnast require any further support? E.g. My child has an aid at school and they would benefit from an aid in gymnastics

Will wheelchair access be required? (If so, a discussion with gymnastics staff regarding chair to trampoline transition procedure required).