



PRE-PARTICIPATION QUESTIONNAIRE

All information on this sheet is confidential.

Access to this sheet is limited to Instructors & First Aid Officers of World Aikido-Yoga.

Personal Details			
Surname:	<input type="text"/>	Given Name(s):	<input type="text"/>
Address:	<input type="text"/>		
Phone:	<input type="text"/>	Mobile:	<input type="text"/>
Occupation:	<input type="text"/>	Email:	<input type="text"/>

Emergency Contact Details			
Surname:	<input type="text"/>	Given Name(s):	<input type="text"/>
Phone:	<input type="text"/>	Mobile:	<input type="text"/>
Relationship:	<input type="text"/>	Email:	<input type="text"/>

Health Care Contact Details			
Preferred Doctor:	<input type="text"/>		
Phone:	<input type="text"/>	Mobile:	<input type="text" value="[Or after hours number]"/>
Preferred Dentist:	<input type="text"/>		
Phone:	<input type="text"/>	Mobile:	<input type="text" value="[Or after hours number]"/>
Other:	<input type="text"/>		
Phone:	<input type="text"/>	Mobile:	<input type="text" value="[Or after hours number]"/>

Miscellaneous	
Have you done any Martial Arts before?	If Yes, please list: <input type="text"/>
Have you done any Yoga before?	If Yes, please list: <input type="text"/>
Have you any other skills or interests?	If Yes, please list: <input type="text"/>
What are you hoping to gain from training in Aikido-Yoga?	Please describe: <input type="text"/>



Medical Details

Blood Group:

Do you object to transfusions? No Yes

Do you take any medications? No Yes

If Yes, please describe:

Have you ever had ...

Epilepsy: No Yes

Hepatitis A: No Yes

Hepatitis B: No Yes

Diabetes: No Yes

Heart Problems: No Yes

Heart Murmur: No Yes

Hernia / Ulcer: No Yes

If Yes, please describe:

Concussion ...

Have ever had Concussion? No Yes

How many times?

Give approx dates:

Vision ...

Do you wear glasses:

No Yes

Hard contact lenses?

No Yes

Soft contact lenses?

No Yes

Teeth ...

Do you have any current dental issues / braces etc ?

No Yes

If Yes, please describe:

Asthma ...

Do you suffer from asthma?

No Yes

Do you take any medication for asthma ?

No Yes

Do you bring your medication to training ?

No Yes

Vaccinations ...

Have you been Vaccinated against:

Hepatitis A: No Yes

Hepatitis B: No Yes

Tetanus: No Yes

Other: No Yes

If Yes, please describe:

HIV Status: (optional)

Allergies ...

Are you allergic to:

Tape: No Yes

Ice: No Yes

Medications: No Yes

Other: No Yes

If Yes, please describe:



Injury Details

Have you been injured In the last 12 months? No Yes

If Yes, please list:

Have you sustained a fracture or dislocation in the last 3 years? No Yes

If Yes, please list:

Are there any past injuries Still effecting your performance? No Yes

If Yes, please list and describe treatment if any (ie. padding / taping / other)

Have you ever had a head, neck or spinal injury? No Yes

If Yes, please list and describe treatment if any (ie. padding / taping / other)



Declaration / Signature

To the best of my knowledge all the information contained on this "Pre-Participation Questionnaire" form is correct (If under 18 years of age, please have a parent or legal guardian complete this form and sign)

Signature:

Date: