

Weightlifting Academy of Tasmania

Health Screening and Medical History

This is a risk factor screening form, which must be completed prior to your first session. The information obtained will be kept confidential within the centre.

Name: _____

Date of Birth: _____ Age: _____ Contact Number: (day) _____

Email: _____

In case of emergency, who do we contact? _____ Phone: _____

1. PERSONAL MEDICAL HISTORY

Have you experienced any of the following conditions? (Please ✓ the appropriate column and give details for your response)

Condition	No	Yes	Details
Rheumatic or scarlet fever			
Heart trouble			
High blood pressure			
Chest pain/Angina			
Stroke			
Undue limited shortness of breath with exercise			
Fainting or blackout			
Epilepsy			
Lung disorder			
Asthma			
Hay fever			
Allergies			
Anaemia			
Diabetes			
Joint problems			
Back injury			
Serious accident or injury			
Surgical operation			
Other serious illness			

In case of an accident or an illness, while on premises of the Academy, do you agree to appropriate medical action being taken? YES / NO

Signed: _____ (Athlete) Signed: _____ (Parent/Guardian if under 18)

Date: _____