

BOOTCAMP 2007

Name.....

Address.....
.....
.....

Email.....

Contact Tel No.....

Exercise History (times per week, type and length of activity).....
.....
.....
.....
.....

AMOUNT DUE: £25 for 4 sessions

LIMITED SPACES AVAILABLE! BOOK NOW TO AVOID DISAPOINTMENT

Please Fill in and return form below!

PAR-Q

Name _____

Date _____

Yes **No** Have you ever been told by a doctor that you have a heart condition and that you should only do exercise recommended by a doctor?

Yes **No** Do you ever feel chest pain when involved in physical activity? Have you experienced chest pain during physical activity in the past month?

Yes **No** Do you ever lose your balance due to dizziness or have you ever lost consciousness?

Yes **No** Do you have a bone or joint problem that could be aggravated by a change in your activity level?

Yes **No** Are you on any prescription medication for blood pressure or a heart condition?

Yes **No** Do you have chronic back pain?

Yes **No** Is there any reason you should *not* exercise?

If you answered **YES** to one or more questions, visit your doctor or talk to him or her by telephone before beginning an exercise program.

Comments:.....
.....
.....
.....

Print Name..... **Sign**..... **Date**.....