



PRE-EXERCISE SCREEN ACRO – CHILD <18

CONTACT DETAILS OF PARTICIPANT				
NAME		DATE		
ADDRESS				
DOB		BOY	<input type="checkbox"/>	GIRL <input type="checkbox"/>
HOME PH		MOBILE PH		
EMAIL ADDRESS				
CURRENT AGE		TOWN	EMERALD	CAPELLA
EMERGENCY CONTACT Parents or Guardian 18+		WORK PH		
		MOBILE PH		
DOCTOR		WORK PH		
		A/HOURS PH		
SINGLET SIZE	SINGLET SIZES 4, 6, 8, 10, 12, 14, 16 Please Circle			

PHYSICAL ACTIVITY QUESTIONS						
1. What type of recreational (sports)/ physical activity do you enjoy if any?						
TEAM SPORTS	SWIMMING	RUNNING	DANCING	GYM	WALKING	OTHER
2. Have you done ACRO or Gymnastics before? If so how many years _____ brief description _____					Yes	No
3. How many times a week, are you involved in physical exercise (sports etc) _____ and for what duration?						
4. Is there anywhere in your body that hurts all the time or only hurts when you participate in physical activity (exercise)? If yes please explain?					Yes	No
YOUR SIGNATURE				DATE		
PARENT SIGNATURE						

