

## MUSCLE-BONE SYSTEM

1. In the last six months, has your child had any muscular pain while exercising?  Y  N

If yes, please explain and indicate where the pain has occurred (eg. 'pain in the back of the right heel' or 'pain on the inside of the right elbow')

1.1 Has a doctor treated this pain?  Y  N

2. In the last six months, has your child experienced joint pain, or pain in the bones?  Y  N

If you, please explain and indicate where the pain has occurred (eg. 'front of right leg' or 'behind the knee bone')

2.1. Has this joint pain, or pain in the bone been treated by a doctor?  Y  N

2.2 Has your child broken any bones or suffered injury to their bones in the last 12 months?  Y  N

If yes, please explain where and how the break/injury occurred: \_\_\_\_\_

## BRAIN-MUSCLE SYSTEM

1. Does your child have, or has your child had difficulty/problems with any of the following?

Vision  Motor sensory skills  Hearing  Poor balance/instability  Speech/language  Sleep apnoea

2. Has your child ever experience a brain or spinal injury?  Y  N

3. Does your child experience difficulty in the skill of:

Climbing up stairs  Walking down stairs  None of the above

## SPECIAL CONDITIONS

1. Does your child use a 'puffer' or 'ventilator' for asthma?  Y  N  N/A

2. Does your child self-administer Insulin for Diabetes?  Y  N  N/A

3. Does your child have any chronic disability or chronic illness?  Y  N

If yes, please indicate the condition  Cerebral Palsy  Hypermobility  ADHD  Obesity  Down Syndrome  
 Intellectual impairment  Other (please specify)

4. Is your child allergic to food, medications, pollens or other allergies or specific environments?  Y  N

If yes, please explain what causes have been identified with this/these allergy/ies

5. Does your child follow a special diet?  Y  N

6. Has your child ever been diagnosed with a nutritional deficiency (such as an iron deficiency)?  Y  N

If yes, please specify the nutritional deficiency

**APPLICATION FORM  
JUNIOR MEMBERSHIP  
2011**



**PERSONAL DETAILS**

Surname		First name	
Date of Birth	School	M / F	
Phone (h)	Mobile		
Postal Address			
State	Postcode	Email	

[PLEASE COMPLETE ALL SECTIONS]

**EMERGENCY CONTACT INFORMATION**

Parent/Guardian Name	
Phone	Mobile
Doctor's Name	Contact Phone

**PROOF OF AGE DOCUMENT**

Please tick your category

<input type="checkbox"/> Student Card
<input type="checkbox"/> Passport
<input type="checkbox"/> Birth Certificate

**OFFICE USE ONLY**

Card No. _____	Valid Y / N
Card No. _____	Valid Y / N
Card No. _____	Valid Y / N

**To help us continually improve our services please answer the following questions:**

**How did you hear about Unigym?**  
 Friends    UTAS Media    Unigym Website    Other (please specify) \_\_\_\_\_

**What activities or facilities have brought you to Unigym?**  
 Les Mills Fitness Classes    Zumba    Circuit Classes    Yoga & Pilates    Spin    Pump  
 Cardio Equipment    Resistance Equipment  
 Tennis    Squash    Sports Hall    Dojo  
 Other (please specify) \_\_\_\_\_

**What time of the day are you most likely to visit?**  
 6.15am to 9am    9am to 1pm    1pm to 4pm    4pm to 7pm    7pm to 9.30pm

**What day are you most likely to visit?**  
 Monday    Tuesday    Wednesday    Thursday    Friday    Saturday    Sunday

**What is the main reason you joined Unigym?**  
 Cost of Memberships    Facilities    Friends    Opening Hours    Programs/classes available  
 Location (convenient)    Staff    Reputation    Other (please specify) \_\_\_\_\_

**MEMBERSHIP TYPE**

Please tick the membership you wish to purchase

<b>12-13 YEARS</b>	<b>3 months</b>	<b>6 months</b>	<b>12 months</b>
	<input type="checkbox"/> \$130	<input type="checkbox"/> \$180	<input type="checkbox"/> \$250
<b>14-15 YEARS</b>	<b>3 months</b>	<b>6 months</b>	<b>12 months</b>
	<input type="checkbox"/> \$193	<input type="checkbox"/> \$250	<input type="checkbox"/> \$360
<b>16-17 YEARS</b>	<b>3 months</b>	<b>6 months</b>	<b>12 months</b>
	<input type="checkbox"/> \$193	<input type="checkbox"/> \$250	<input type="checkbox"/> \$360
<b>FACILITY MEMBERSHIP</b>	<b>1 month</b>	<b>12 months</b>	
	<input type="checkbox"/> \$10	<input type="checkbox"/> \$50	
<b>ZUMBATOMIC® (4 - 12 years)</b>	<b>5 sessions</b>	<b>10 sessions</b>	
	<input type="checkbox"/> \$25	<input type="checkbox"/> \$50	

**INFORMED CONSENT**

**I hereby acknowledge that:**

The information provided above regarding my child's health is, to the best of my knowledge, correct.

I will inform you immediately if there are any changes to the information provided.

I acknowledge that I have been provided with a copy of the terms and conditions applicable to my child's Unigym membership. I have been informed, and understand, that I should make myself aware of all applicable terms and conditions before signing my child up for membership, as I will be bound by them where my child becomes a member. I specifically acknowledge that my attention has been drawn to the terms and conditions relating to responsibility for personal injury that my child might suffer when participating in activities at Unigym.

Parent/guardian signature	Date
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**UNIGYM STAFF ONLY**

**PLEASE TICK**

1. New member       Renewing member
2. Health screen completed  - Stage One completed and member notified of suitable exercise intensity  
 - Stage Two (if applicable) completed and member notified of suitable exercise intensity  
 Witness: \_\_\_\_\_ Date: \_\_\_\_\_
3. Medical Clearance form given  Yes  No      Date received \_\_\_\_\_
4. Induction completed  Date completed \_\_\_\_\_
5. Informed client about Clause 6 of Terms and Conditions.
6. Client Given:    General TC Version 1.1       UTAS Staff STC Version 1.1       UTAS Student STC Version 1.1   
 Community Concession STC Version 1.1       Fixed Term STC Version 1.1       Session Card STC Version 1.1   
 Monthly Membership / Direct Debit STC Version 1.1       Facility STC Version 1.1
7. Issued card to client.
8. Have attached copy of relevant document or sighted discount cards.
9. Client application: Accepted     Denied     Reason \_\_\_\_\_

I understand that if my child exercises above the agreed intensity recommended by Unigym staff, that they do so at their own own risk.

SIGNATURE	DATE
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# EXERCISE AND PHYSICAL ACTIVITY READINESS ASSESSMENT OF CHILDREN AND YOUNG ADOLESCENTS (EXPAPA)\*

Important information for parents/guardians

The purpose of this form is to ensure we provide every child and/or adolescent with the highest level of care. For most children, physical activity provides an opportunity for children and adolescents to have fun and promotes the basis for good health and an enhanced quality of life for the future. However, there are a small number of children or adolescents who may be at risk when participating in an exercise/physical activity program. We ask therefore that you read and complete this questionnaire carefully and return it to a Unigym staff member in charge. The information in this form is confidential and is subject to the laws and regulations contained in the Privacy Laws enacted in December 2001.

## PERSONAL DETAILS

Name	Date of Birth	M / F
Height (cm)	Weight (kg)	BMI
How old was your child as at 1 January this year?		
Name/s of parent/s or guardian/s		
Home address		
Private home contact ph	Work ph	Mobile ph
Has a GP or specialist referred your child?	Doctor's name	Contact ph
If there is an emergency, specify the person who should be contacted and their emergency phone number:		
Name	Contact ph	

**Please note:** In case of a medical emergency, an ambulance may be used to transport your child to the nearest medical treatment service.

## GENERAL HEALTH

1. Has your child had surgery in the previous 12 months? <input type="checkbox"/> Y <input type="checkbox"/> N
2. Are you aware of any medical reason/condition which might prevent your child from participating in an exercise program? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please explain
3. What are your child's favourite hobbies and interests?

## HEART-LUNG-OTHER SYSTEMS

<b>1. Does your child have, or has your child had:</b> <input type="checkbox"/> A heart condition (please specify) <input type="checkbox"/> Diabetes (Type I or II – please specify) _____ <input type="checkbox"/> High blood pressure (specify when last taken) <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> High cholesterol <input type="checkbox"/> Unexplained coughing during or after exercise <input type="checkbox"/> Breathing problems or shortness of breath (for example, asthma, emphysema)
<b>2. Does your child experience or has your child experienced:</b> <input type="checkbox"/> Epilepsy or seizures/convulsions (if yes, is it at rest or during exercise?) <input type="checkbox"/> Fainting <input type="checkbox"/> Dizzy spells <input type="checkbox"/> Heart stroke/heart-related illness <input type="checkbox"/> Increased bleeding tendency/haemophilia <input type="checkbox"/> Other (please specify)
<b>3. Does your child have, or has your child had, an eating disorder?</b> <input type="checkbox"/> Y <input type="checkbox"/> N
<b>4. Does your child take any medications for</b> (please name) <input type="checkbox"/> Heart problem <input type="checkbox"/> Epilepsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Attention Deficit Disorder (ADD) <input type="checkbox"/> Asthma, breathing problems <input type="checkbox"/> Allergies <input type="checkbox"/> Blood pressure <input type="checkbox"/> Other (please specify)
4.1 If your child is taking any medication, please state if there are any side effects experienced as a result of taking this medication.