SHARE
Building healthier communities

POST COVID-19
CONFIDENTIAL PRE-ACTIVITY QUESTIONNAIRE

Name: ____Age:_______ Date of Birth: ___/___/___ Sex: M/F

Address: ____ Postcode: ___________

Phone: (H) ___________________________ (Mob) ____________________Email: _________________________

Emergency Contact Name: _____________________________Best Contact Number: ________________________

COVID19 CLEARANCE

Have you been in close contact with a confirmed case of Coronavirus in the last 14 days?	Yes / No
Do you currently have any respiratory symptoms such as fever, cough, runny nose, sore throat	Yes / No
If YES to any of the above questions, please contact your GP or Health Direct @ 1800 022 222 and wait their advice on when you are fit and well to attend.	
If at any stage, you develop flu like symptoms, you MUST NOT attend (DO NOT COME IN TO THE CLASS). Please see your GP or contact Health Direct and wait their advice on when you are fit and well to attend.	Yes / No
If at any stage, you are suspected OR diagnosed with COVID19, you MUST inform SHARE office immediately	Yes / No

SECTION A

HAVE YOU EVER HAD OR DO YOU HAVE? **Circle the correct response**

High Blood Pressure	Yes / No	Stomach/Duodenal Ulcer	Yes / No
Low Blood Pressure	Yes / No	Liver/Kidney condition	Yes / No
High Cholesterol/Triglycerides	Yes / No	Diabetes	Yes / No
Pain/tightness in the chest	Yes / No	Epilepsy	Yes / No
Rheumatic Fever	Yes / No	Hernia	Yes / No
Any Heart/Stroke condition	Yes / No	Back Pain	Yes / No
Osteoporosis	Yes / No	Breathing difficulties or Asthma	Yes / No
Gout	Yes / No	Arthritis	Yes / No

SECTION B

A family history of heart disease, stroke or raised cholesterol of relatives under age 65?	Yes / No
Do you smoke cigarettes / pipe / cigar?	Yes / No
Do you have muscular pain / cramps?	Yes / No
Have you had any major injuries? Please describe	Yes / No
Have you exercised before? How often? How recently?	Yes / No
Are you on any prescribed medication? Please explain what conditions this medication is taken for?	Yes / No
Have you had any major surgery? If yes, how long ago and describe? Does your GP need to agree to this program? **If Yes** Please obtain approval	Yes / No
Do you have or have you had recently any infections or infectious diseases? Please describe	Yes / No
Are there any other conditions or illnesses, which may limit your activity program? Please describe	Yes / No
Participants Engaging in Water Exercise (AQUA) must answer this question. Do you suffer from INCONTINENCE?	Yes / No
Is there anything else your Instructor should be aware of?	

Participants MUST at all times observe and adhere to SHARE policies, procedures, regulations and COVID19 Safety Plan. Centres at which classes are held have strict guidelines please adhere to these including their Notice Boards with important information in relation to SHARE classes. Failure to do this is at your own risk. SHARE reserves the right to refuse participants from attending SHARE classes.

The participant acknowledges these physical activities may be strenuous and may involve inherent risk of physical injury. The participant agrees to assume all risk and responsibility involved with participation in these physical activities.

DECLARATION: I, the undersigned, acknowledge that the above assessment includes participation in physical activities, including but not limited to, various exercises I have enrolled in.

I, the undersigned, certify that the information I have given on this form is complete and accurate.
In my opinion, there is no medical reason why I should not take part in the SHARE Exercise program. I understand that all safety precautions will be observed and I accept that there is a small risk associated with undertaking any exercise Program. I have completed this form and I understand it. I will notify my Instructor of any changes to my health by completing a new questionnaire.

Witness Name: ____ Relationship: _________________________

Signed Witness: ____Date: _______________________________

Signed Participant: ____Date: _______________________________

If you answer YES in Section A, a Health Professional who consents to you participating in physical activities as per the class description must give their approval below. Or you may sign this form on behalf of your local GP taking in consideration that you will be liable for any concerns arise.

HEALTH PROFESSIONALS APPROVAL

Health Professional Job Title e.g. General practitioner: ____

Name: ____ Phone: __________________________

Address: ____ Postcode: ________________________

Signed: ____ Date: ____________________________

Thank you for joining one of SHARE classes, we hope you achieve your desired outcome and enjoy our programs.

Please Return Completed Forms

M: P O Box Kogarah 281 NSW 1485 | Office: Suite 1A, 124 Forest Rd Hurstville 2220
P: 8580 0628| E: info@share.org.au | W: Share.org.au