Student Induction Form





Name			D.O.B
Address			Phone
	F	Post Code	Mobile
Name of who to con	tact in an emergency		
(& relationship to stu	udent):		Phone
MEDICAL INFORMA	ATION		
Please state any med	dical conditions which may be ag	gravated by exercise	
Please circle any of t	he following that apply		
Heart Trouble	High Blood Pressure	Chest Pains	Nervous Disorders
Migraine	Haemophilia	Diabetes	Faint / Dizzy Spells
Asthma	Seizures	HIV	Hernia
ADD/ADHD	Back Pain	Hay fever	Allergy
Other			
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