SCREENING FORM

CHILD'S NAME: .....

ADDRESS: .....

TEL NO: ..... MOBILE NO: .....

AGE: ..... DATE OF BIRTH: .....

PLEASE COMPLETE THE FOLLOWING:

DOES ANY OF YOUR IMMEDIATE FAMILY SUFFER FROM ANY HEART CONDITION?	YES ☐	NO ☐
DOES YOUR CHILD HAVE ASTHMA?	YES ☐	NO ☐
DOES YOUR CHILD SUFFER FROM DIABETES?	YES ☐	NO ☐
DOES YOUR CHILD SUFFER WITH EPILEPSY?	YES ☐	NO ☐
DOES YOUR CHILD HAVE ANY MUSCLE, BACK, JOINT DISORDER?	YES ☐	NO ☐
IS YOUR CHILD TAKING ANY MEDICATION?	YES ☐	NO ☐
HAS YOUR CHILD HAD SURGERY WITHIN THE PAST 3 MONTHS?	YES ☐	NO ☐
HAS YOUR CHILD EVER HAD AN INJURY WHILE EXERCISING?	YES ☐	NO ☐
DOES YOUR CHILD HAVE ANY MEDICAL CONDITION?	YES ☐	NO ☐

IF YOU ANSWERED YES TO ONE OR MORE OF THE ABOVE, WRITTEN CERTIFICATION FROM YOUR DOCTOR CONFIRMING YOUR CHILD'S ABILITY TO PARTAKE IN EXERCISE MAY BE REQUIRED.

PARENT SIGNATURE: .....

THANK YOU FOR YOUR COOPERATION

EASTER CAMP REGISTRATION

Payment required at time of booking.
Advance bookings required due to limited numbers.

Name(s): .....

Address: .....

..... Tel: ..... Age(s): .....

Please tick which Camp(s) you wish to attend: **1** ☐ **2** ☐ **Teen Camp** ☐

How did you find out about the Camp? .....

Cheque/ Cash enclosed for € .....

Please make cheque payable to 'Tralee Regional Sports & Leisure Centre

Staff Signature: .....

Receipt No.

For more details Contact Hayley Rogers on:

Telephone: 066 7126442 • Email: hrogers@traleesportscentre.ie

www.traleesportscomplex.ie