

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 <input type="checkbox"/> | NO <input type="checkbox"/> |
| DOES YOUR CHILD HAVE ASTHMA? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| DOES YOUR CHILD SUFFER FROM DIABETES? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| DOES YOUR CHILD SUFFER WITH EPILEPSY? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| DOES YOUR CHILD HAVE ANY MUSCLE, BACK, JOINT DISORDER? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| IS YOUR CHILD TAKING ANY MEDICATION? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| HAS YOUR CHILD HAD SURGERY WITHIN THE PAST 3 MONTHS? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| HAS YOUR CHILD EVER HAD AN INJURY WHILE EXERCISING? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| DOES YOUR CHILD HAVE ANY MEDICAL CONDITION? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

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

SUMMER 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 3 4 5 6 7

How did you find out about the Camp?

Amount Paid €

Staff Signature:

Receipt No.:
