TRALEE REGIONAL
Sports & Leisure CENTRE

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

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** ☐

Teen Camp 1 ☐ **Teen Camp 2** ☐

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.