



Men's Moves Registration

Name:..... D.O.B:.....
Address:.....
Phone:..... Email:.....

Emergency contact: Name:..... Relationship:.....
Address:..... :.....
Phone:..... Mobile:.....

Do you identify as Aboriginal or Torres Strait Islander? Yes No
Are you from a CALD background? Yes No
Do you require any additional support that will assist you in participating in this activity eg interpreter, wheelchair access Yes No

I have the following conditions that need to be considered: *Please Tick*

<input type="checkbox"/> Asthma	<input type="checkbox"/> Back problems	<input type="checkbox"/> Sight impairment
<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Joint Replacement
<input type="checkbox"/> Stroke	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Other

Are you taking any medication for this condition?

My current level of activity is: *Please tick.*

No regular exercise Small amount of exercise Regular Exercise

Please comment on the type of regular exercise you are doing:

I understand that all safety precautions will be observed but agree to accept full responsibility for any loss or damage to personal property or any injury which may be sustained while taking part in the class.

I'm aware that in the event of a medical emergency an ambulance may be called for me at my expense.

Signed

Date