



# PCYC Membership Form

PLEASE COMPLETE IN CLEAR BLOCK LETTERS

## MEMBERSHIP TYPE (Please tick)

<b>Type:</b>	Adult [ ] Concession Holder [ ] Sports Club [ ] Family [ ] Under 5 [ ] Police Officer [ ] Student [ ] Senior Concession [ ] OR <b>Direct Debit</b> Fortnightly [ ]
<b>Concession</b>	[ ] Health Care Card [ ] Pension Card [ ] Seniors Card [ ] Student Card

## MEMBER DETAILS:

Surname:		First Name:	
Date of Birth:		Gender: eg Male/Female/Other	Phone:
Address:		Suburb:	

Email: \_\_\_\_\_

## EMERGENCY CONTACTS:

Full Name:		Full Name:	
Relationship:		Relationship:	
Mobile Phone:		Mobile Phone:	

## WEIGHTS GYM INDUCTION

I am interested in a PCYC Induction (please complete form) [ ]

I am not interested and agree to sign to the below [ ]

I am not interested because I believe I have an advanced level of prior knowledge as well as extensive practical experience and assume complete responsibility for my training. I have been advised to undertake an induction and do not do so at my own request.

I have **read and understood** the Membership **Disclaimer & Waiver Release and Indemnity** and I agree to all terms and conditions. I acknowledge, understand and agree to all of the information of these forms.

.....  
New Member Signature

.....  
Parent's Signature (if under 18yrs)

.....  
Date

### OFFICE USE ONLY

Staff Member Info: Form Received by \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Membership AMOUNT PAID \$ \_\_\_\_\_ Date Paid \_\_\_/\_\_\_/\_\_\_ Payment Method EFT / CASH / CHQ / DD



# Medical Clearance Participant Questions

It is important that you check out any possible risk to your health and safety with your doctor before you start your exercise program. The aim of the questions below is to identify the small number of people whom fitness appraisal might be inappropriate, and those who should seek medical advice before undertaking exercise. *Thank you for your co-operation!*

Please answer the following questions as accurately as possible:

	YES	NO
1. Have you ever had a problem with your heart? Or has your doctor indicated a problem?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever suffered from a stroke? Provide details & year:	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have high or low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you on any prescribed medication eg. High blood pressure, cardiac condition etc?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have a chronic or acute illness? Provide detail:	<input type="checkbox"/>	<input type="checkbox"/>
6. a) Do you smoke? (tick) <input type="checkbox"/> Yes <input type="checkbox"/> No For how many years? _____ years How many per day? _____ av		
6b) Do you ever struggle to breathe? Do you ever become breathless? OR Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have a diagnosed or suspected bone or joint problem? <i>EG: Arthritis that has been aggravated or made worse by exercise?</i>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any exercise limitations?	<input type="checkbox"/>	<input type="checkbox"/>
9. Please detail any other medical condition/s that you have had, or have, that you feel may effect your capacity to undertake activities at the PCYC eg: Asthma, dizzy spells, chronic fatigue, polio, or other conditions. Details:	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you at currently participate in regular Physical Activity? <i>What type of exercise? _____ How often do you participate? _____ per wk</i>		

## MEDICAL CLEARANCE

**If you answered YES to one or more questions** you MUST gain the approval / consent of your doctor before undertaking any exercise program and provide a MEDICAL CLEARANCE to participate. **Please provide the details of your regular doctor**

Doctor's Name..... Phone.....  
Address..... Suburb.....

Attached is my Doctor's Medical Clearance slip, indicating that I am cleared to undertake the exercise program.

Attached are exercise prescription outline & limitations details from my doctor / specialist (cardio /weight-bearing / other)

I, the undersigned have read and answered the above pre-fitness evaluation questions truthfully, and to the best of my knowledge. I will inform the instructor about my limitations verbally so they are aware. But I recognise that the instructor/supervisor is not able to provide me with medical advice with regard to my medical fitness and that this information is used as a guideline to the limitations of my ability to exercise. Where I answered yes to any question/s I agree not to participate in any fitness program until I have discussed the issue with my doctor to ensure that it is safe for me to begin. I undertake all exercise programs at the Launceston Police and Citizens Youth Club freely and voluntarily and that the Management and staff will not be liable for any personal injury arising through participation.

Signed by Participant: \_\_\_\_\_ Signed by Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_