

Pre-Activity Readiness Questionnaire



Norfolk County Council
at your service

Course Number		Tutor	
Date		Title	
Surname		First Name	
Address			
Telephone		Date of Birth	
Next Of Kin			
Contact No.			

For your own safety, please complete the following questions regarding your Health:

(please tick)

- 1 Has your Doctor ever said you should NOT take part in physical activity? YES ☐ NO ☐
- 2 Has your Doctor ever said that you have a heart condition? YES ☐ NO ☐
- 3 Has your Doctor ever said that you have high/low blood pressure? YES ☐ NO ☐
- 4 Are you taking any medication for your blood pressure or heart condition? YES ☐ NO ☐
- 5 Do you have Diabetes Mellitus or any other form of Diabetes? YES ☐ NO ☐
- 6 Do you, or have you recently felt pain in your chest when doing physical activity? YES ☐ NO ☐
- 7 Do you ever lose balance, become dizzy or ever lose consciousness? YES ☐ NO ☐
- 8 Do you have any injuries that could be aggravated by exercise? YES ☐ NO ☐
- 9 More specifically, do you have any joint problems including back, knees and/or neck? YES ☐ NO ☐
- 10 Has anyone in your immediate family had a heart attack prior to the age of 55 years? YES ☐ NO ☐
- 11 Has your Doctor ever said you have raised cholesterol levels? YES ☐ NO ☐
- 12 Have you ever been short of breath, had difficulty breathing or been diagnosed with asthma? YES ☐ NO ☐
- 13 Do you suffer from Epilepsy? YES ☐ NO ☐
- 14 Are you or do you think you may be, pregnant? YES ☐ NO ☐

15 Have you had or are you in recovery from any major surgery including pregnancy in the last 6 months? If yes please give details below.

YES ☐ NO ☐

Is there any other reason, medical or otherwise that may affect your ability to exercise? Please comment.

We strongly advise that if you have not participated in regular physical exercise prior to beginning this activity, you should seek advice from your doctor

Safety Agreement

I understand that the responsibility of my fitness to participate rests with me.

I agree to abide by any verbal or written instruction given by my designated Tutor and observe all written notices regarding safety whilst at the designated venue.

I declare that to the best of my knowledge this information is correct

I will notify my tutor of any changes in my medical condition.

Signature

Name (Print)

Date

I understand that the information I have given on this form will be held in confidence and in accordance with the provisions of the Data Protection Act 1998. The information will be held by Norfolk Adult Education Service for use in educational and training administration. It will also be passed to your course tutor who will retain the information on their course files. The information will be destroyed at the end of the course or in two years time if you continue to enrol in classes with the same tutor. I further understand that I can withdraw my consent to the processing of this information at any time.

For Staff use only:

2 year date of information destruction

Action taken as a result of readiness questionnaire results