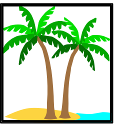
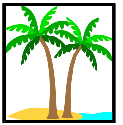


APPLICATION FORM



To apply for membership of The Paradise Sports Centre to run until 30th September of current year, please hand completed form into reception with your payment.

To gain admittance to the Centre as a member, you will be required to either swipe your membership card. This will be set up once your application has been processed.

Title: Mr/Mrs/Miss/Ms *Delete as required* **Full Name (1)**.. **Date of Birth** .... **Gender M/F/NA** *Delete as required*

Address .... **Home Tel** ....

.... **Work Tel** ....

.... **Mobile** ....

Postcode .... **Email** ....

Person to contact in emergency ....

Relationship to you ....

Home Tel .... **Work Tel** .... **Mobile** ....

Please tick required membership option:

Family £........... ☐ **Adult £**........... ☐ **Concessions £**........... ☐ **Membership not required** ☐

Family names (family membership only)

Family member (2) .... **Date of Birth** .... **Gender M/F/NA**

Family member (3) .... **M/F/NA**

Family member (4) .... **M/F/NA**

Waivers of claims: Although the questions overleaf are designed to help our staff to advise you about the safety of exercise, you are reminded that our staff cannot be held responsible for your health. It is your responsibility to consult with your doctor if you are in any doubt about the safety of exercise.

In consideration of the Paradise Centre and their staff, agreement to instruct, assist and advise me, I do here and forever release and discharge and hereby hold harmless Paradise Centre and their staff from all claims, demands, damages, rights of action or causes of action, present or future, arising out of or connected with my participation in any exercise including any injuries resulting from there.

Signed: .... **Date:** ....

PTO

Office administration				
Date	***Amount Paid***	***Signed***	***Membership ID***	***Card Number if issued***

MEDICAL QUESTIONNAIRE

Name of Doctor Surgery .... **Surgery Tel** ....

Have you suffered from any of the following complaints (please tick your answer)

Family member 1	2	3	4	5		Family member 1	2	3	4	5	
					Asthma						**Back Problems**
					Bronchitis						**Faint/Dizzy Spells**
					Heart Trouble						**Low Blood Pressure**
					Diabetes						**High Blood Pressure**
					Epilepsy						**Stress/Panic Attacks**
					Stroke						**Cancer**

1	2	3	4	5	
					Do you smoke, if yes, how many daily ....
					Are you pregnant, or have you had a baby in the last 6 months
					Have you had an operation in the last 6 months, if yes, give details......................................

....

1	2	3	4	5	
					Have you suffered an injury, which still causes you problems, if so give details

....

Arthritis/Joint Pain

Family member 1	2	3	4	5		Family member 1	2	3	4	5		Family member 1	2	3	4	5	
					Neck						**Back**						**Hips**
					Knees						**Ankles**						**Shoulders**
					Elbows						**Wrists**						**Other areas**

1	2	3	4	5	
					Are you under any medication, if so give details of what it is for, how long you have used it,

and any relevant side effects. ....

....

Please briefly detail any form of dieting, fasting or calorie restriction programme you are following

....