**Live Well Registration Form**

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| --- | --- |
| **SURNAME** |  |
| **FIRST NAME AND INITIAL** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **HOME ADDRESS**  No/house name  Street  Town  Post code  EMAIL ADDRESS  TEL House and mobile | |  | | | |
| **EMERGENCY CONTACT** | Name and  Relationship | |  | Tel: Home  mobile |  |

**SOME PERSONAL DETAILS**

|  |
| --- |
| Have you attended any classes previously – if so where and when? |
| Which venues do you prefer attending?  DUNBAR, HADDINGTON, NORTH BERWICK, MUSSELBURGH, ORMISTON, TRANENT **(please circle)** |
| HOW MIGHT YOU LIKE TO CONTRIBUTE (in person or financially) TO THE CHARITY?  (payments can be done in cash, bank transfer, standing order or Just Giving donation) |
| ANY SPECIAL INTERESTS/TALENTS/QUALIFICATIONS which would help our Charity please?  (or fundraising opportunities) |

If willing to make donation by **Standing Order** please ask us for the appropriate form.

***Please see overleaf for details of Gift Aid and where to return this form:***

**Charity Gift Aid Declaration**

**Boost your donation by 25p of Gift Aid for every £1 you donate**

Gift Aid is reclaimed by the charity from the tax you pay for the current tax year. Your address is needed to identify you as a current UK taxpayer.

**In order to Gift Aid your donations you must tick the box below**:

I I want to Gift Aid my donation today and any donations I make in the future or have made in the past 4 years to:

**Name of Charity : Live Well East Lothian**

**Charity No: SC046920**

I am a UK taxpayer and understand that if I pay less Income Tax and / or Capital Gains Tax than the amount of Gift Aid claimed on all my donations in that tax year it is my responsibility to pay any difference.

**Please notify the charity if you:**

* want to cancel this declaration
* change your name or home address
* no longer pay sufficient tax on your income and/or capital gains

If you pay Income Tax at the higher or additional rate and want to receive the additional tax relief due to you, you must include all your Gift Aid donations on your Self Assessment tax return or ask HM Revenue and Customs to adjust your tax code.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature** |  | **Date** |  |

*Many thanks. Please return this membership form either to our CLASS INSTRUCTOR, or by post to:*

**The British Society of Lifestyle Medicine, Room 12 Haddington House, 28 Sidegate, Haddington, East Lothian, EH41 4BU.**

**Health Questionnaire (ParQ)**

Before you attend your class, please complete this form, and bring it with you to your first class. This information will help the instructor to give you the correct advice and make sure that the activities are safe and effective for you.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name:** | |  | | | | |
| **Address:** | |  | | | | |
| **Postcode:** | |  | | | | |
| **Telephone**  **Number:** | |  | | | | |
| **Mobile Number:** | |  | | | | |
| **Email Address:** | |  | | | | |
| **GP Contact**  **Details:** | |  | | | | |
| **Emergency**  **Contact:** | | Name: Contact Number: | | | | |
|  | | Relationship: | | | | |
|  | |  | | | | |
| If you answer **YES** to any of the following questions, please discuss these exercise classes with your doctor or relevant health professional before attending. This is because the exercises may need to be adapted to meet your needs or they may not be suitable for you. | | | | | | |
|  | |  | | | | |
| **Questions:** | |  | | | **Yes** | **No** |
| Have you ever had a medical advice NOT to exercise? | | | | |  |  |
| Do you feel pain in your chest when you do physical activity? | | | | |  |  |
| Do you lose your balance because of dizziness? | | | | |  |  |
| Do you ever lose consciousness? | | | | |  |  |
| Do you get breathless doing daily activities? | | | | |  |  |
| Have you ever been told you have a heart condition, angina or high blood pressure?  If YES, circle the following: | | | | |  | |
| Heart Attack | | Angina | High Blood Pressure | Arrhythmias |  | |
| Coronary Bypass | | Stents | Implantable devices | Other? |  | |
| **Questions:** | |  | | | **Yes** | **No** |
| Are you on any of the following medication? If YES, circle which: | | | | |  |  |
| Beta Blockers | | ACE Inhibitors | Calcium Blocker | GTN Spray |  | |
| Aspirin/  Clopidogrel | | medicines to thin  blood e.g. Warfarin | Diuretics | Other? |  | |
| Have you ever had a stroke or mini-stroke? | | | | |  |  |
| Do you have diabetes? | | | | |  |  |
| If YES, please circle which: Type 1 Type 2 | | | | |  |  |
| Are you on Insulin or oral medication? | | |  | |  |  |
| **Questions:** | | |  | | **Yes** | **No** |
| Do have a bone, joint, muscular or neurological condition that affects your ability  to take part in physical activity? If YES, please circle which one | | | | |  |  |
| Back Pain | | Osteoporosis | Multiple Sclerosis | Epilepsy |  | |
| Parkinson’s Disease | | Chronic Fatigue | Arthritis | Other? |  | |
| Do you have a knee or hip replacement? If YES, please explain. | | | | |  |  |
| Do you currently have Cancer or are a Cancer survivor? If YES, are you currently  on any treatments e.g. chemotherapy, radiotherapy, hormone therapy? | | | | |  |  |
| Have you had any surgery or an operation in the past 12 months?  If Yes, please explain. | | | | |  |  |
| Have you had a fall in the last 12 months? | | | | |  |  |
| Do you have any other needs (e.g. walking aids, physical disability, hearing or sight difficulties?) If YES, please explain. | | | | |  |  |
| **Please bring any GTN spray or inhalers to class with you.** | | | | |  |  |
| **Please provide any information of Current Medications to the instructor –** | | | | |  |  |
| **Declaration:** | | | | |  |  |
| * The information I have given is correct, to the best of my knowledge * If my answer to any of the questions changes, I will let the instructor know straight away and I will not take part in the class until I have done so. * This information will be stored securely in accordance with the GDPR. No personal identifiable information will be made public or shared with any other organisation. | | | | |  |  |
| I am taking part in these classes voluntarily and entirely at my own risk | | | | |  |  |
| **Print Name:** |  | | | |  |  |
| **Signature:** |  | | | |  |  |
| **Date:** |  | | | |  |  |

**PARKING PERMITS**

**CAR REGISTRATION:**

***Please see overleaf for the Disclaimer Form.***

**Live Well East Lothian Disclaimer**

Informed Consent and Liability Waiver Release for Participation in a Live Well Class.

I agree and consent to the following:

I am voluntarily participating in a class conducted by Live Well.  I recognise that the class requires some physical exertion that may cause an injury and I am fully aware of the risks and hazards involved.

I understand that it is my responsibility to consult with a health professional prior to and regarding my participation in any Live Well class.  I represent and warrant that I have no medical condition that would prevent my participation in the class.  If I have a pre-existing condition I confirm I have consulted my GP Practice and it has approved my participation as per the PARQ document offered.

I agree to assume full responsibility for any risks, injuries or damage known or unknown which I might incur as a result of participating in the class.

I, my heirs or legal representation knowingly, voluntarily and expressly waive any claim I may have against Live Well or its personal instructors for injury or damages that I may sustain as a result of participating in a class.

I have read the above waiver and release of liability and fully understand its contents.  I voluntarily agree to the terms and conditions stated above.

**Signature:**

………………………………………………

**Print Name:**

……………………………………………..

**Date:**

……………………………………………..