

Participant Health Declaration Form

The activities involved in the Jockey Club “The Year of Go!” Series includes various physical activities. For safety purposes, participants and parents are required to fill out the following declaration form and ensure that all information provided is accurate, complete, up-to-date, and true. This will allow staff and instructors to understand the participant's physical condition.

(1) Fitness Activity Adaptability

Question	Yes(✓)	No(✓)
1. Has your doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor?		
2. Do you feel pain in your chest when you do physical activity?		
3. In the past month, have you had chest pain when you were not doing physical activity?		
4. Do you lose your balance because of dizziness or do you ever lose consciousness?		
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?		
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?		
7. Do you know of <u>any other reason</u> why you should not do physical activity?		

****All "No" Answers:** If you have answered "No" honestly to all the questions on this questionnaire, there is reason to believe that you are suitable to participate in the activity.

****One or More "Yes" Answers:** Before starting the activity, please contact or consult with a doctor in person, informing them about this questionnaire and the questions to which you answered "Yes." The doctor will assess whether it is appropriate for you to participate in the activity.

(2) Participant's Medical History:

Limbs Injury:	No(✓)	Yes (Please briefly describe the information)
head		
neck		
shoulders		
hand		
back and waist		
lap		
ankle		
joint		
other		

Serious, Long-term or Congenital Diseases:	No(✓)	Yes (Please briefly describe the information)
epilepsy		
heart disease		
hypertension		
diabetes		
asthma		
flat feet/wide flat feet		
O-shaped feet/X-shaped feet		
night blindness		
other		

Allergy:	No(✓)	Yes (Please briefly describe the information)
drug sensitivity		
food sensitivities		
sensitive skin		
sensitive hair		
animal sensitive		
other sensitive		

Special learning needs and psychological conditions:	No(✓)	Yes (Please briefly describe the information)
hearing impairment		
visual impairment		
physical weakness		
mentally retarded		
inattention and hyperactivity		
autism/Asperger's syndrome		
dyslexia		
gifted		
special psychological conditions: such as depression and anxiety		

Other :	No(✓)	Yes (Please briefly describe the information)
Have you had any major surgery in the past six months?		
Activities that doctors do not recommend		
Are you a vegetarian?		

* The information provided in the Participant Health Declaration Form will be used solely for the purpose of processing the registration for the activity by authorized staff. If the registration is not accepted, all related personal information will be destroyed. For successful registrants, their personal information will be stored in the files for future follow-up by authorized staff.

Participant's name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Parent/guardian contact number: _____

Date: _____