AllFit registration form

1. Do you qualify for the program? Tick box below that is appropriate for your circumstance?

   - ○ Permanent physical disability
   - ○ Temporary physical disability
   - ○ Mental health illness
   - ○ Chronic or debilitating illness
   - ○ Other

   Please provide a letter of referral from a health professional or Centrelink benefit card at time of registration at the Centre.

2. Adult Pre-Exercise Screen system. **Please tick YES or NO**

	YES	**NO**
Has your medical practitioner ever told you that you have a heart condition or have you ever suffered a stroke?	○	○
Do you ever experience unexplained pain or discomfort in your chest at rest or during physical activity/exercise?	○	○
Do you ever feel faint, dizzy or lose balance during physical activity/exercise?	○	○
Have you had an asthma attack requiring immediate medical attention at any time over the past 12 months?	○	○
If you have diabetes (type 1 or 2) have you had trouble controlling your blood sugar (glucose) in the last 3 months?	○	○
Do you have any other conditions that may require special consideration for you to exercise?	○	○

If you answered YES to any of the 6 questions, please seek guidance from an appropriate allied health professional or medical practitioner prior to undertaking exercise.

3. Do you require a gym exercise program?

   - ○ Yes
   - ○ No

If yes, please provide medical clearance detailing exercise limitations or contraindications to gym staff prior to your gym appointment.

4. Personal Information

First Name: ______________________ Last Name: ______________________

Date of birth: ______________________ Gender: ______________________

Address: ____

Email: ______________________ Phone: ______________________

5. How did you hear about us? ______________________

6. Emergency Contact details

Name: ______________________ Relationship: ______________________

Email: ______________________ Phone: ______________________

7. Will a carer or personal care worker be assisting you in the facility? Yes: ○ No: ○

Carer Contact Name: ____

Carer Contact email: ____

Organisation name and contact details: ____

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YOU HAVE TO AGREE TO OUR TERMS AND CONDITIONS

○ I acknowledge that I need to abide by the Victorian Government requirements in relation to Covid 19 to access this facility *

○ I believe that to the best of my knowledge, all the medical information I have supplied within this page and attachment is correct *

○ I agree to receiving promotional emails and centre updates from Aqualink

* Agreement is required

Name: ____

Signature: ______________________ Date: ______________

PRIVACY – The personal information requested on this form is necessary to manage and provide membership services. This information will be used solely by Aqualink and Whitehorse City Council for that / those primary purpose(s) or directly related purposes. The intended recipients of the information are Council officers, authorised external service providers, contractors and consultants. Council may disclose the information to law enforcement agencies, courts and other organisations authorised to collect it. Individuals have a right to seek access to their personal information and make corrections by using Aqualink's Online Client Portal or emailing Aqualink at aqualink.enquiry@whitehorse.vic.gov.au. You may view Council's Privacy Policy on our website www.whitehorse.vic.gov.au or obtain a copy from any of the Council offices.

LIABILITY – To the extent permitted by law, Aqualink and the City of Whitehorse shall not be liable or responsible to you for any direct, indirect or consequential injury, loss or damage whatsoever and however arising. Aqualink and the City of Whitehorse are not responsible for lost or stolen items or damage to property or vehicles. Acknowledging this risk, you agree to use the Centres at your own risk.