



Beazley Reserve
 160 Thames Promenade Chelsea Heights, 3196
 Reg No: A18134X - ABN: 40977 443281
 Phone: 03 9772 3391
 Email: office@chelseaheightscommunitycentre.com.au
www.chelseaheightscommunitycentre.com.au

CLASS ENROLMENT FORM

1st July 2024 - 30th June 2025

PERSONAL CONTACT DETAILS				
First Name:		Last Name:		
Age group: <input type="checkbox"/> <18 <input type="checkbox"/> 19 – 40 <input type="checkbox"/> 40 – 64 <input type="checkbox"/> 65+				
Address:				
Suburb:		Postcode:		
Phone number:				
Email:				
Relevant medical information, e.g. allergies, special requirements:				
EMERGENCY CONTACT DETAILS				
Name:				
Phone number:		Relationship:		
PROGRAM(S) ENROLLED IN				
CHILD/CHILDREN ATTENDING ACTIVITY (IF APPLICABLE)				
First Name	Last Name	Date of Birth	Relationship with the applicant (parent/grandparent/carer/nanny)	Relevant medical information, e.g. allergies, special requirements
TERMS AND CONDITIONS				
CLASS ENROLMENT:	You must fill in this form and pay before commencing any activity. If a class is cancelled due to unforeseen circumstances or low attendances, CCHC will contact all participants where possible to advise of the cancellation and refund conditions. We have a strict class refund policy. If you decide to cancel your booking prior to the start of the class, refunds will be issued if at least seven days' notice is given prior to class/workshop commencement date. An administration fee of \$20 will be deducted.			
ENROLMENT FEE:	A \$5 per financial year enrolment fee (non-refundable) is required from all participants in CHCC programs and activities. This must be paid on enrolment.			
COVID-19:	You agree to comply with all COVID-19 current requirements and confirm you will not attend the activity if unwell and will notify CHCC or the activity provider immediately if yourself or a family member has been diagnosed with COVID-19.			
PRIVACY STATEMENT:	It is the policy of the Chelsea Heights Community Centre to maintain the highest level of confidentiality for information provided by its participants. Information collected is either required by law or necessary for the running of the activity you are enrolled in. The handing in of this completed, signed form signifies your approval to use your information for those purposes. The privacy policy 6.2 is available upon request from the office.			
EMERGENCY MEDICAL TREATMENT:	I agree to CHCC seeking, or where appropriate, administering, such emergency medical treatment as is deemed necessary, and you will reimburse any reasonable expenses incurred by CHCC.			
PHOTOGRAPH AND VIDEO AUTHORITY:	I give permission to CHCC to use your photograph and/or video for the promotion of activities at the Centre in either printed or online supports.			<input type="checkbox"/> Yes <input type="checkbox"/> No
COMMUNICATION:	Would you like to be included in our email update listing to receive information about free workshops/events & further information about the Centre?			<input type="checkbox"/> Yes <input type="checkbox"/> No
DECLARATION: <input type="checkbox"/> I have read and understand the TERMS AND CONDITIONS				
Signature:			Date :	

Office use only
 Database

Received by

Receipt no

Date
/...../.....

Please Turn Over

ADULT PRE-EXERCISE SCREENING

AIM: to identify those individuals with a known disease, or signs or symptoms of disease, who may be at a higher risk of an adverse event during physical activity/exercise. This stage is self-administered and self-evaluated.

1.	Are you pregnant? If pregnant, how many weeks? _____	Yes	No
2.	Have you recently given birth? <input type="checkbox"/> I declare I have given birth recently and I have received clearance from my healthcare practitioner (six-week check-up) to return to exercise.	Yes	No
3.	Are you new to regular exercise and over 35?	Yes	No
4.	Has a doctor ever advised that you have heart problems, high blood pressure or cardiovascular problem?	Yes	No
5.	Do you ever experience unexplained pains in your chest at rest or during physical activity/exercise?	Yes	No
6.	Do you ever get headaches, feel faint or have spells of dizziness during physical activity/exercise that causes you to lose balance?	Yes	No
7.	Do you suffer from pain, limited movement or recuperating from a recent illness or operation? (e.g., arthritis)	Yes	No
8.	Have you ever had or have the following (please tick) <input type="checkbox"/> High cholesterol/triglycerides <input type="checkbox"/> Epilepsy <input type="checkbox"/> Asthma <input type="checkbox"/> Back problems <input type="checkbox"/> Stroke <input type="checkbox"/> Muscle problems <input type="checkbox"/> Gout <input type="checkbox"/> Diabetes	Yes	No
9.	Do you have any allergies/sensitivities that we should be aware of? If yes, please provide details/action plan:		
10.	Do you take any prescription medicines?		
IF YOU ANSWERED 'YES' to any of the 10 questions, please seek guidance from your GP or appropriate allied health professional prior to undertaking physical activity/exercise.			
IF YOU ANSWERED 'NO' to all the 10 questions, and you have no other concerns about your health, you may proceed to undertake light-moderate intensity physical activity/exercise.			

Disclaimer: Participation in outdoor exercise class/bike riding will at times involve using public pathway/roads and other surfaces shared by other uses on foot and in vehicles and hereby release, exempt, and indemnify either Volunteer Leader/Class tutor and Chelsea Heights Community Centre from all action, proceedings, demands, costs, expenses, and claims made or taken by a person arising from my participation in the ride/event indicated.

I, the person described in this form, recognise that the instructor is not able to provide me with medical advice regarding my fitness, and that this information is used as a guideline to the limitations of my ability to exercise.

I have answered the above questions to the best of my ability and understand the advice above.

I am aware that undertaking an exercise program will involve some physical activity and in undertaking such activities, I do so, at my own risk. I am also aware that my instructor/Centre/staff is absolved from all liability how so ever arising from any injury or damage. I am aware, there is always a very small risk that taking any form of exercise may reveal an unknown health defect or weakness which can lead to injury, illness or even fatality.

Should you suffer any illness, injury, or condition in the future, please tell us by completing this form again.

I confirm that I am physically and mentally confident to undertake the activities involved in this exercise program.

Participant's name:	Instructor's name:
Date:	Date:
Signature:	Signature: