COUGARS Weightlifting Club Inc.
ABN 60 992 960 816

Ph: 0403283810

AFFILIATED WITH THE QUEENSLAND WEIGHTLIFTING ASSOCIATION INC.

MEMBERSHIP FORM

Name:	
Email:	Date Of Birth:
Address:	
Home Phone:	Mobile:
Occupation:	Coach:

Significant Medical History: (eg. epilepsy, diabetes, heart disease, joint injury/replacement, sight/hearing disabilities, allergies)

Exercise History:
What sport/exercise programs have you been involved with in the past?

What sports/exercise programs are you involved in now?

How did you find out about Cougars Weightlifting Club?

I, the undersigned, hereby apply for membership of Cougars Weightlifting Club and agree to be bound by the Safety and Membership Rules of the Club for the time being in force. See our website http://www.qwa.org/qwaclubs/cougars/documents/GymSafetyandRules.pdf for more details on gym safety and club rules.

_____ _____
Signature of Applicant Date

_____ _____
Signature of parent if Applicant under 18 years of age Date

Fees can only be paid electronically see - http://www.cougarsweightlifting.com/fees/ for full details on the monthly fees and yearly membership.
It is a condition of access to the gym that all members swipe in on their arrival.

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Getting more people active through sport and recreation

Brisbane City

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Health screening questionaire

Please read the following questions carefully and circle **YES** or **NO** opposite the question as it applies to you:

Yes	No	Do you have a history of cardiovascular disease including heart attack, stroke, Heart failure, atherosclerosis, heart valve disease etc.?
Yes	No	Have you ever had cardiovascular surgery including coronary bypass, open heart Surgery, angioplasty etc.?
Yes	No	Do you frequently have pains in your heart or chest region?
Yes	No	Do you often feel faint or have severe dizzy spells?
Yes	No	Has your doctor ever told you that your blood pressure is too high and that you may have a problem with your blood pressure?
Yes	No	Do you have any bone or joint problems such as arthritis or an old sporting or work injury which you or your doctor think may be made worse if you exercise? Please list: ……
Yes	No	Have you ever suffered from a stroke?
Yes	No	Are you over 35 years of age?
Yes	No	Are you pregnant or have you recently given birth?
Yes	No	Do you have palpitations or an irregular heart rate?
Yes	No	Have you ever been told you have high cholesterol?
Yes	No	Have you ever suffered from asthma, emphysema or bronchial disorders?
Yes	No	Do you have diabetes, epilepsy or anemia?
Yes	No	Do you, or have you ever had cancer?
Yes	No	Have you ever suffered from glandular fever, chronic fatigue syndrome or periods of prolonged fatigue?
Yes	No	Do you have any family history (mother, father, brother, sister, aunt, uncle) of any above mentioned conditions, diseases, illnesses?
Yes	No	Is there any other medical or health reasons that you can think of which would prevent you from increasing your physical activity? Please list: ……
Yes	No	Do you take any medications which you or your doctor think may affect you during an exercise program?

If you answered yes to any of the above questions, clearance from your local doctor is necessary.

Signature of Member_____Date _____

Signature of Coach _____Date _____

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