HEALTH SCREENING FORM

Balance Boot Camp Health Screening Form

Participant Name: _____

Date of Birth: _____

Contact Information: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Health Questions

Please answer the following questions truthfully. If you answer "Yes" to any of these questions, please provide additional details and consult your physician before participating.

1. Do you have any current or past medical conditions that could affect your ability to participate in physical activity (e.g., heart disease, diabetes, asthma, joint injuries)?
   - Yes ___ No ___
   - If yes, please describe: _____
2. Have you had any surgeries or injuries in the past that could limit your ability to participate in the program?
   - Yes ___ No ___
   - If yes, please describe: _____
3. Are you currently on any medication that might affect your participation or cause any issues during physical activity?
   - Yes ___ No ___
   - If yes, please describe: _____
4. Do you have any allergies (e.g., food, medication, etc.) that we should be aware of in case of an emergency?
   - Yes ___ No ___
   - If yes, please describe: _____
5. Have you consulted with a physician regarding your ability to participate in the Balance Boot Camp program?
   - Yes ___ No ___
   - If no, please consult your physician before participating.

Acknowledgment and Consent

I, the undersigned, confirm that the information I have provided is accurate and complete to the best of my knowledge. I understand that it is my responsibility to notify the program organizers of any changes to my health status. I acknowledge that the organizers may deny participation based on health concerns if necessary.

Participant Signature: _____

Date: _____