Name/Student Number .....
Sex:.....
Date of Birth .....

Health Screen and Physiological Testing Questionnaire

As an individual participating in physical activity, it is important that you are currently in good health. This is to ensure your well-being and to try and for a period of three years. After this time it will be SHUPDQHQWO\ GHOHWHG. Please ask for a photocopy of this questionnaire if you require one.

Please complete this brief questionnaire to confirm your ability to participate:

1. At present, do you have any health problem for which you are:

(a)	on medication, prescribed or otherwise	Yes	☐	No	☐
(b)	attending your general practitioner.....	Yes	☐	No	☐
(c)	on a hospital waiting list for an injury	Yes	☐	No	☐
(d)	recovering from an illness or operation	Yes	☐	No	☐

2. In the past two years, have you had any illness or injury which required you to:

(a)	consult your GP	Yes	☐	No	☐
			☐	No	☐
(c)	be admitted to hospital	Yes	☐	No	☐

3. Have you ever had any of the following:

(a)	Convulsions/epilepsy	Yes	☐	No	☐
(b)	Respiratory conditions such as asthma/bronchitis/ Turburculosis……..	Yes	☐	No	☐
(d)	Eczema	Yes	☐	No	☐
(e)	Diabetes	Yes	☐	No	☐
(f)	A blood disorder (including infections/viruses) ..	Yes	☐	No	☐
(g)	Head injury including concussion.....	Yes	☐	No	☐
(h)	Digestive				
			☐		☐
(l)	Dizziness / black outs / fainting	Yes	☐	No	☐
(m)	Disturbance of vision	Yes	☐	No	☐
(n)	Ear/hearing problems	Yes	☐	No	☐
(o)	Thyroid problems	Yes	☐	No	☐
(p)	Kidney or liver problems	Yes	☐	No	☐
(q)	Problems with blood pressure (low or high)	Yes	☐	No	☐
(r)	A pacemaker	Yes	☐	No	☐

(s) Chronic obstructive pulmonary disease (COPD) Yes ☐ No ☐

(t) Anaphylactic shock symptoms to needles, probes or other medical-type equipment Yes ☐ No ☐

(u) Any allergies or food intolerances Yes ☐ No ☐

(v) A history of heart disease in the family Yes ☐ No ☐

(w) Been pregnant or given birth in the last 6 months Yes ☐ No ☐

(x) Rectal problems Yes ☐ No ☐

If YES to any question, please describe in more detail if you wish (for example, was the problem short lived, if it is controlled, if it is re -occurring, if your doctor has given you specific information/instructions regarding the problem).

.....

.....

4. Please state what medication (if any) you are currently taking, explain briefly what the medication is for and how long you have been taking it.

……

5. Do you have any other condition or disability that you feel we should be aware of?

Yes ☐ No ☐

If yes, please briefly explain below :

……

6. Are you currently involved in any other lab activity at the University or elsewhere?

Yes ☐ No ☐

If yes, please provide details.

……

7. Please provide contact details of a suitable person for us to contact in the event of any incident or emergency.

Name: …… Relationship to Participant: ……..

Telephone Number: Work ☐ ☐ ☐

SUBJECT CONSENT FORM

UNIVERSITY of BEDFORDSHIRE

Name of person requesting consent _____

qatT2 5(t)6.2 6(i)2.5 5(w)3.7 8omsat he iedurtatabrt

Title of practical / procedures: _____

Date and approximate time to be carried out: _____

I confirm that I understand the nature of the practical test above and what is involved in the protocol outlined. I further confirm that my health is normal and the information given on the health/medical questionnaire is accurate and complete. I understand that there are foreseeable risks associated with the procedures and I understand that I may experience some discomfort during the procedures