# Dynamic Balance for Life (DBfL) Enrolment Form

**Adelaide University Judo Club Inc.**

Adelaide University Sports Association Adelaide University, Adelaide SA 5005

### Family Name: Given Names:

Date of Birth: Telephone No:

Email address:

Address:

Suburb: Postcode:

Gender

**Other Information**

Have you had a fall in the last 12 months? Yes / No

If Yes, what was the outcome:

Where did you hear about the program?

DBfL involves full body movement, and therefore involves some risk. Please ask your Coach to explain the risks to you if you have not done anything similar before.

***The Program is endorsed and supported by Judo Australia, the peak body for judo in Australia!***

**Disclaimer**

Release, Indemnity and Assumption of Risk.

In consideration of being permitted to participate in these AUJC training sessions, I hereby release, remise, discharge and agree to indemnify the Adelaide University Judo Club and JudoSA, their respective officers, executives, directors, officials, agents against all claims, actions, costs, expenses and demands in respect of injury, death, loss of damage to my person or property, howsoever caused, arising out of or in connection with my participation in judo training.

I agree to assume all risks, both known and unknown, and all consequences thereof, arising out of or in connection with my participation in this program.

*I certify that:*

* I am aware that there is a risk of injury related to the nature of learning to fall safely.
* I am in good physical condition and have no injuries, disease, disability or pre-existing conditions that may affect my likelihood of injury, that I have not disclosed overleaf.
* No physician, nurse, therapist, trainer, coach, manager or other person has advised me NOT to participate in this program.
* I undertake at all times to abide by ***The Adelaide University Judo Club Code of Conduct*.**

This document shall be binding on myself, my heirs, executors, administrators assigns and personal representatives. I have read this document, understand that I give up substantial rights by signing it and knowing this, sign it voluntarily. I agree to participate knowing the risk and conditions involved and do so entirely upon my free will.

###  / /

 *Participants signature Date*

***PTO.***

A member of the Adelaide University Sports Association Affiliated to the Judo Federation of Australia (South Australia) Inc.

**Medical Information** Your Name:

**Emergency Contact Information**

### Name: Relation to you:

Telephone No:

**Medical History**

Do you have a disability which could affect your participation? Yes / No

If Yes, please give brief details:

Are you currently taking any blood thinning medication? Yes / No:

If Yes, please give brief details:

Do you have any recurring injuries or current medical problems which could be affected by activity? Yes / No If Yes, please give brief details:

*Have you ever had:*

|  |  |
| --- | --- |
| Yes / No | Heart condition, e.g. angina, cardiovascular disease, congestive heart failure |
| Yes / No | Neurological condition, eg, epilepsy, stoke, Parkinson’s, MS, MND |
| Yes / No | Atlantoaxial instability, excessive movement at the junction between C1 and (C2) |
| Yes / No | Neck or spinal injury/problems | Yes / No | Uncontrolled High blood pressure |
| Yes / No | Detached retina | Yes / No | Uncontrolled Low blood pressure |
| Yes / No | Fracture or dislocation in last 3 yrs | Yes / No | Back or knee problems |
| Yes / No | Asthma or respiratory condition | Yes / No | Arthritis |
| Yes / No | Hernia | Yes / No | Severe Osteoporosis |
| Yes / No | Vertigo or Motion Sickness |  Yes / No  | Concussion |
| Yes / No | Heart murmur |  |  |

If you normally wear Glasses, Contact lenses and/or Dentures, please circle the appropriate words.

### Is there any other medical or safety-related information which you believe may be relevant to your participation?

If you answered YES to one or more of the questions above, you will need to consult your Doctor or allied health professional (Physiotherapist or exercise physiologist) in person for a clearance (please download the Medical clearance form) about participating in the program.

Signature: Date: