RIDE 4 KIDS 2018

INCORPORATING BRAD FOSTER CYCLE CHALLENGE & DALTON'S RIDE

PARTICIPANT QUESTIONNAIRE & PRE CYCLE SCREENING FORM

This information sheet is designed to ensure The KIDS Foundation has all the details needed to plan and conduct your bike ride. All the information provided will be treated as 'Confidential' and will only be shared with the necessary authorities if required.

PLEASE COMPLETE THIS FORM AND RETURN IT A.S.A.P. TO KIDS FOUNDATION

PO Box 12, Wendouree, VIC 3355 or scan and email to events@kidsfoundation.org.au

Ride 4 KIDS 2018

CONTACT DETAILS	
FULL NAME:	
NEXT OF KIN – Person to be contacted in the event of an emergency.	
Given Name:	Surname:
Mobile:	Email:

PHYSICAL DETAILS	
Sex: Male / Female	Age:
Weight (kg):	Height (cm):
Cigarette Smoking: Never Ex-smoker Current Smoker (please circle)	
Ex-Smoker – How long ago?:	Current Smoker – Number per day:

HOW WOULD YOU RATE YOUR PERSONAL FITNESS? (Circle one only)							
Very Poor	Poor	Below Average	Average	Above Average	Good	Excellent	Superior
Please describe your current level of fitness in particular, cycling:							

On average, how many sessions would you exercise (cycle) weekly and for how long (please circle)?

a) One b) Two c) Three d) Four e) Five f) Six g) Seven

a) 15 mins b) 30 mins c) 45 mins d) 60 mins e) 60 – 90 mins f) over 90 mins

What cardiovascular activity do you currently undertake? *E.g. running, cycling, etc.*

Do you currently see any of the following? If so, please provide details.

Doctor	
Physiotherapist	
Personal Trainer	
Other e.g. Chiropractor	

Do you currently have an injury or illness? Y / N

Diagnosis/ Description
Current Treatment
Medications:

Have you had any previous injuries or surgeries? Y / N Date Injury / Surgery

Details:

CARDIOVASCULAR		
Do you develop any tightness, discomfort or pain in your chest or back when you do physical activity (work or exercise)?	Yes	No
Do you develop any tightness, discomfort or pain in your chest or back when you are not doing physical activity?	Yes	No
Do you ever experience palpitations (irregular heart beat)?	Yes	No
Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor, for example a heart murmur, high blood pressure, irregular heart beat or Marfans Syndrome?	Yes	No
Is your doctor currently prescribing medication (e.g. water pills) for your blood pressure or heart condition?	Yes	No
Do you ever lose balance because of dizziness or do you ever lose consciousness?	Yes	No
Do you know of any reason why you should not do physical activity?	Yes	No
Have you ever experienced shortness of breath or fatigue?	Yes	No
Have you ever suffered from poor circulation?	Yes	No
Have any of your relatives died prematurely (<50 years old), or experienced disability as a result of heart disease?	Yes	No
RESPIRATORY		
Have you ever been diagnosed with any lung or breathing problem that requires continued treatment (e.g. Asthma/Emphysema)?	Yes	No
Have you ever been prescribed oral steroids as part of a treatment protocol for Asthma? **If so, it is compulsory to attach a treatment protocol from your doctor to this document.**	Yes	No
ORTHOPAEDIC/MUSCULOSKELETAL		
Do you have a joint or bone problem that could be made worse by a change in your physical activity?	Yes	No
Have you ever had an operation on your hip, knee or back?	Yes	No
Have you had any operation on a bone or joint in the last 5 years?	Yes	No
Do you develop any pain in the following areas after exercise? Ankle	Yes	No
Knee	Yes	No
Hip	Yes	No
Lower back	Yes	No
Neck	Yes	No
Have you had back pain at any time in the last 2 year that has stopped you from doing your normal activities?	Yes	No
Do you suffer from arthritis?	Yes	No
Do you suffer from any other athletic injury?	Yes	No

If you have answered yes to any of the above, please provide details below and mark the injury on the attached figure:

Please identify on the diagram below if you currently have or have had a major / minor injury.

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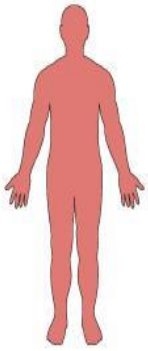

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Further comments please (e.g. right knee reconstruction 1997):

OTHER	(Please circle)	
Do you ever have episodes of dizziness, fainting or collapse?	Yes	No
Do you suffer from hernia?	Yes	No
Do you suffer from diabetes?	Yes	No
Dietary Requirements		
Special dietary requirements:		
Allergies		
Please list all known allergies: Reaction: Date of last reaction: Treatment protocol:		
Have you ever suffered anaphylaxis? If so, it is essential you provide us with a treatment protocol from your doctor and bring two EpiPens with you on your ride.	Yes	No