2019 MEDICAL CLEARANCE FORM
CHALLENGE 2

This form must be completed and signed by a registered doctor or nurse
Complete this form within the 4 weeks before the start of challenge

All fields marked with * are mandatory fields

*First Name:	*Last Name:
*DOB: / /	*Preferred phone number:
Has the participant had 715 health check in the past 12 months *A 715 health check should be completed within 6 months of starting the challenge*	☐ Yes ☐ No

*Please indicate if the participant:

- ☐ has experienced a cardiac event or asthma attack requiring immediate medical attention in last 12 months
- ☐ has unstable or untreated heart or circulatory disease
- ☐ has a history of undiagnosed chest pain
- ☐ has a history of unexplained faintness
- ☐ has a history of unexplained shortness of breath
- ☐ is post-surgery under 3 months (including but not limited to cardiac surgery, joint replacement, wound healing)
- ☐ is pregnant

If any boxes are ticked above or the participant has any other medical conditions which require monitoring, a doctor must assess fitness to participate in the challenge.

*Please indicate:

- ☐ Any medical conditions are being monitored
- ☐ I confirm the participant is fit to participate in the challenge

***Doctor/Registered Nurse (please circle)**

***Name (print):** _____

***Health Service/Organisation (please include stamp if available):** _____

***Signature:** _____ **Date:** _____

2019 INITIAL WEIGHT ASSESSMENT FORM
CHALLENGE 2

Complete this form within the 2 weeks before registration closes

All fields marked with * are mandatory fields

*Team Name:		
*Name:		*DOB: / /
*Height (cm)	*Initial Weight (kg) (1 decimal point)	*Waist (cm)

HEALTH PROFESSIONAL (e.g. doctor, nurse, AHW, dietitian etc):
I have reviewed the participant information and confirm the submitted weight data as a true and accurate record.

*Name (print):	*Position & Organisation
*Signature:	*Date: