**Consultation and Consent form for Sports Therapy Treatments**

|  |  |
| --- | --- |
| **Client name** : | **Doctor** : |
| Address: | Address: |
| Telephone: | Telephone: |
| Date of birth: Age | |
| Occupation:  email | |

|  |  |
| --- | --- |
| Sports club | **Exercise** : None Regular Trained |
| **REASON FOR VISIT**: | |

I understand that if certain conditions below are highlighted I should seek medical advice and obtain a doctor’s note if necessary before treatment.

I understand that I must inform the person delivering the treatment of any changes to my medical condition or other relevant conditions.

**PLEASE CIRCLE ANY THAT APPLY**

|  |  |  |
| --- | --- | --- |
| **Total contra-indications** | **GP consent required** | **Local contra-indications** |
| Fever | Pregnancy | Skin conditions |
| Contagious disease | Thrombosis | Varicose veins |
| Drugs | Recent operation | Pregnancy (abdomen) |
| Alcohol | High Blood pressure | Cuts/grazes |
| Cancer | Low blood pressure | Bruising |
| Neuritis inflammation | Medication | Scar tissue |
| Notes: | Heart conditions | Sunburn |
| Covid 19 please complete separate form | Notes: | Menstruation |
|  | Arthritis | Allergies |
|  | Asthma severe | Asthma mild or exercise induced |
|  | Nervous disorder | Notes: |
|  | Epilepsy |  |
|  | Diabetes |  |
|  | Medical oedema |  |

**GP consent required YES NO GP consent obtained YES NO**

Client signature.......................................................... Date ..............................................................

I consent for maintain and train to hold electronic records purely for the purpose of communications and at no point will this information be passed to a third party

Signature ……………………………………………….. Date …………………………………………………..

DATA REGISTRATION ZA334564

# CONSULTATION & CONSENT DOCUMENT – SPECIFIC COVID-19 SCREENING

|  |  |  |  |
| --- | --- | --- | --- |
| **FULL NAME** |  | | |
| **FULL ADDRESS** |  | | |
| **POST CODE** |  | | |
| **EMAIL ADDRESS** |  | | |
| **MOBILE NUMBER** |  | | |
| **Temperature on entry Andy Chalmers temperature** | | | |
| Have you had a Covid-19 test in last 3 weeks | | YES | NO |
| Did you self-isolate | | YES | NO |
| What was the date you tested negative or positive | |  | |
| Do you still have symptoms | | YES | NO |
| Are you registered on the NHS Track &Trace app | | YES | NO |
| SYMPTOMS - Are you experiencing any of the following covid symptoms? | | | |
| Chills or headache | | YES | NO |
| Painful swallowing | | YES | NO |
| Muscle & joint ache | | YES | NO |
| Fatigue or exhaustion | | YES | NO |
| Loss of taste or smell | | YES | NO |
| Shortness of breath or difficulty lying down due to chest issues | | YES | NO |
| **SIGNED**  I solemnly and sincerely declare that the information I have provided is true and correct and I make this solemn declaration conscientiously believing the same to be true. If any person should suffer as a result of the information being found to be untrue and false, then I am aware I can be prosecuted for making a false declaration.  If either I or someone I have been in contact with tests positive for Covid-19 or have been contacted by NHS Track & Trace I will inform you.  I consent for you to inform NHS Track & Trace if so required.  Signature ………………………………………………  GDPR DATA REGISTRATION ZA334564  Date: ……………………………… | | | |