

Enderby & District Recreation Services



Health Screening Form 2024

**please fill out completely

DATE : _____

Name : _____	Birth date _____ / _____ / _____	Age : _____
Phone # : _____	(yyyy/mm/dd)	
Doctor : _____		
*Emergency contact : _____	Phone # : _____	

SPECIAL CONSIDERATIONS : _____

MEDICATIONS : _____

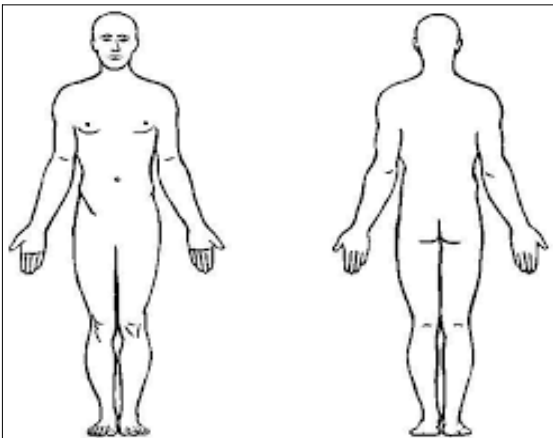
****ALLERGIES :** _____

Subjective Pain Level

on a Scale of 1-10, circle your current pain level

1 2 3 4 5 6 7 8 9 10

Mark areas on your body where you feel described sensations.
Use the appropriate symbol. Include all affected areas.



- | | |
|-----------------|------------|
| X NUMBNESS | + BURNING |
| O PIN & NEEDLES | = STABBING |

Other Notes : (or Dr's Note / Referral)

O.K to participate in fitness class

Dr.'s Signature : _____

Date : _____