



AUTHORISATION TO EXERCISE.

Please return the completed form and give to your Trainer at your first class.

Client Details

Name _____

Address _____

Phone _____

Email _____

GP/Specialist Details

Name _____

Address _____

Phone _____

Email _____

Studio Location/s _____

Absolute contraindications:

Please inform us if the above client has/develops any of the following absolute contraindications to exercise during their pregnancy (please circle).

Ruptured membranes	Yes/No
Preterm labour	Yes/No
Hypertensive - high blood pressure disorders of pregnancy	Yes/No
Incompetent cervix	Yes/No
Growth restricted foetus	Yes/No
Triplets or more	Yes/No
Placenta previa after 26 weeks	Yes/No
Persistent 2nd or 3rd trimester bleeding	Yes/No
Uncontrolled Type 1 diabetes, thyroid disease	Yes/No
Any other serious cardiovascular, respiratory or systemic disorder	Yes/No

Relative contraindications:

Please inform us if the above client has/develops any of the following relative contraindications to exercise during their pregnancy (please circle).

Previous miscarriages	Yes/No
Previous preterm birth	Yes/No



Continued: Relative contraindications:

Mild/moderate cardiovascular disorder	Yes/No
Mild/moderate respiratory disorder	Yes/No
Anemia (HB <100g/L)	Yes/No
Malnutrition or eating disorder	Yes/No
Twin pregnancy > 28 weeks	Yes/No
Other significant medical conditions	Yes/No

Warning signs:

Please advise your patient of any warning signs that exercise should cease immediately including:

- Vaginal bleeding
- Chest Pain
- Dyspnoea before exertion
- Muscle weakness
- Dizziness
- Calf pain or swelling
- Headache
- Onset of labour
- Decreased foetal movement

Additional Comments:

Recommendation:

Taking into consideration all the contraindications and warning signs listed on this form, do you recommend the above client to exercise during their pregnancy at KX?

Yes/No

Date _____ GP/Specialist Signature _____

GP/Specialist Name _____

Date _____ Client Signature _____

Client Name _____