

Applicant Personal Details

Surname Postal Address

Given names

Phone Number Email

D/O/B

EMERGENCY CONTACT DETAILS

Name Mobile Number:

Relationship to applicant

Are you eligible for any concessions? Student ID Card Health Care Card Pensioner Concession Card
 Seniors or DVA Concession Card Trinity College Discount No Concession Card sighted (OFFICE USE ONLY)

Medical Update (select relevant boxes below) Please provide updates to your current medical information that is different to the information previously provided to STARplex. *This section is a legal requirement of all AUSactive registered services.*

1	Do you have asthma?	<input type="checkbox"/> No (Skip to Q.3)	<input type="checkbox"/> Yes	
2	Is your asthma controlled by medication?	<input type="checkbox"/> Yes		<input type="checkbox"/> No
3	Do you have diabetes?	<input type="checkbox"/> No (Skip to Q.5)	<input type="checkbox"/> Yes	
4	Is your diabetes controlled?	<input type="checkbox"/> Yes		<input type="checkbox"/> No
5	Do you suffer from high/low blood pressure? (High / Low)	<input type="checkbox"/> No (Skip to Q.7)	<input type="checkbox"/> Yes	
6	Is your blood pressure controlled?	<input type="checkbox"/> Yes		<input type="checkbox"/> No
7	Do you have any allergies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
8	Do you take any medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	
9	Do you have epilepsy?	<input type="checkbox"/> No		<input type="checkbox"/> Yes
10	Have you been hospitalized within the last 3 months?	<input type="checkbox"/> No		<input type="checkbox"/> Yes
11	Has your doctor ever told you that you have a heart condition or have you ever suffered a stroke?	<input type="checkbox"/> No		<input type="checkbox"/> Yes
12	Do you ever experience unexplained pains in your chest at rest or during physical activity/ exercise?	<input type="checkbox"/> No		<input type="checkbox"/> Yes
13	Do you ever feel faint or have spells of dizziness during physical activity/exercise that causes you to lose balance?	<input type="checkbox"/> No		<input type="checkbox"/> Yes
14	Do you have any diagnosed muscle, bone or joint problems that you have been told could be made worse by participating in physical activity/exercise?	<input type="checkbox"/> No		<input type="checkbox"/> Yes
15	Do you have any other medical conditions that may make it dangerous for you to participate in physical activity/exercise?	<input type="checkbox"/> No		<input type="checkbox"/> Yes

If you have no other concerns about your health, you may proceed to your gym induction, if required, and undertake prescribed light-moderate physical activity/exercise.

If you have answered any questions in the yellow column, please list all medications you take and/or all allergies you have in the space provided below. If you have no other concerns about your health, you may proceed to your gym induction, if required, and undertake prescribed light-moderate physical activity/exercise.

If you have answered any questions in the red column, please seek written guidance from your GP or appropriate allied health professional prior to undertaking physical activity/exercise.

Please list any additional medical conditions, medications or vaccinations: Medical Clearance (OFFICE USE ONLY)

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What would you like to do today?

- I would like to renew/continue on the following program.....
- I would like to enrol in the following **new** program:
- I would like to upgrade / downgrade from to

**Do you need a personalised program to help guide your fitness goals?
Sign up to Personal Training...**

Have you had a personal trainer before? Yes No

I would prefer a Male Female Either.....(Please note: Personal Training requests may not be met)

SELECT PERSONAL TRAINING PACK: 3 PT PACK 10 PT PACK DIRECT DEBIT PT..... week/fortnight

Availability (please specify possible days and either am/pm times):

- MONDAY** am pm.....
- TUESDAY** am pm.....
- WEDNESDAY** am pm.....
- THURSDAY** am pm.....
- FRIDAY** am pm.....
- SATURDAY** am pm.....
- SUNDAY** am pm.....

Please note: We will do our best to try to match your preferred times.

Additional Information:

Membership Fees & Terms

- I would like to pay my membership by: Special Locked in.....months direct debit
- Ongoing Periodic Billing by Direct Debit Fixed Term Upfront Pre-Payment for the term/visits of
- New commencement date:..... New Expiry Date:.....

Pro rata or Upfront amount of \$.....

Direct Debit Fortnightly payment amount of \$.....

Direct Debit Rejection Fee \$.....

TOTAL PAYMENT TODAY \$.....

Cash to Reception Eftpos

SIGNING SECTION
By signing this Membership Application Form you are agreeing to all STARplex Terms, Conditions and Guidelines found on our website: www.starplex.com.au

<p>Signed by the Applicant</p> <p>.....</p>	<p>Signed by Parent/Guardian if under 18yrs</p> <p>.....</p>
<p>Signed by and on behalf of STARplex</p> <p>.....</p> <p>Name.....Position.....Date.....Time.....</p>	