

Student Health Questionnaire

To be completed by yoga class participants for face to face and remote teaching. All information given will be treated in the strictest confidence and stored in accordance with Data Protection legislation.

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Telephone  Mobile:  Home: |  |
| Emergency Contact Name | Tel No: |  |
| Have you attended a yoga class before? | |
| If yes, how long have you practiced yoga and what style of yoga have you practiced? | |

The following information is required to ensure your safety. Whilst yoga may be practiced safely by most people there are certain conditions which require special attention. If you are unsure, please consult your GP before commencing class. Please tick the boxes below if you have any of the following medical conditions:

|  |  |  |  |
| --- | --- | --- | --- |
| These conditions require specific modifications to your yoga practice. If yes, please give details | | | |
| Abdominal disorder or recent surgery |  | Arthritis (osteo or rheumatoid |  |
| Unspecified back pain/ problem |  | Spinal surgery |  |
| Joint replacement |  | Knee problems |  |
| Hip problems |  | Shoulder or neck problems |  |
| Heart disorders |  | High blood pressure |  |
| Low blood pressure |  | Other |  |
| Further information: | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| These conditions may affect your practice and so provide useful information for your teacher | | | |
| Asthma |  | Diabetes |  |
| Anxiety / depression |  | Auto-immune disorder e.g. ME, MS |  |
| Epilepsy |  | Balance affecting disorder |  |
| Respiratory issues |  | Migraine |  |
| Sensory disorder affecting your eyes or ears |  | Other (discuss with your teacher) |  |

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| --- | --- |
| Please tick this box if you do not wish to declare medical information |  |
|  | |
| Have you had any recent operations (in the last 2yrs) |  |
|  | |
| Do you have any old injuries that still trouble you? Or any other medical conditions not covered above that might be adversely affected by your yoga practice |  |
|  | |
| Are you / could you be pregnant or have you given birth in the last 6 weeks |  |
|  | |
| Do you participate in any other physical activities e.g. gym, running, cycling, etc |  |
|  | |
| How regularly do you do this? | |
|  | |
| How did you hear about this class? | |

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| DECLARATION  I confirm the above information is correct and that I take responsibility for my own health and safety whilst participating in the yoga class whether face to face or remotely. I also understand that it is my responsibility to:   * Check with my doctor if I have any difficulties or concerns about my ability to participate in the yoga class * Advise my yoga teacher of any change in my medical information or ability to participate in the yoga class * Follow the advice given by my doctor and/or yoga teacher | |
| Name (please print): |  |
| Signed: |  |
| Date: |  |

In order for me to comply with the General Data Protection Regulations, it is necessary to check whether or not you are happy for me to retain your contact details and to email you information I think will be useful regarding class updates and events. I only hold information when it is necessary for me to carry out my work and when you have given me permission to do so. Please indicate below whether you wish to receive communication:

|  |  |  |
| --- | --- | --- |
| Email | Yes | No |
|  |  |  |
| Please note that you are able to amend these choices at any time by contacting me | | |