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Ultimate Spin in the Environmental Chamber

Consent form

To be completed by the participant or a parent.

Have you been informed about the environmental chamber?	YES / NO
Have you been able to ask questions about the chamber procedure(s)?	YES / NO
Are you fully aware of any discomfort or risks, which may be associated with the procedure(s)?	YES / NO
Have you been informed about the medical and emergency support that is available?	YES / NO

Use of results

All information will be treated as confidential and will only be released to a third party with the consent of the participant. All the information will be stored on the computer in accordance with the Data Protection Act 2002 and will not be used for research purposes by Ulster University.

DECLARATION BY THE PARTICIPANT/PARENT

I have been fully informed about the procedure(s) that will take place and I fully agree to take part in use of the environmental chamber. I am aware that I may withdraw from the unit at any time without the need for explanation. However, I also realise that I will be charged for the session.

Signed____

Date____

DECLARATION BY THE INVESTIGATOR

I confirm that I have informed the participant of the nature and effect of the chamber procedure(s) to be administrated and the participants' consent has been given freely and voluntarily.

Signed____

Date____

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HEALTH HISTORY QUESTIONNAIRE

Any information contained herein will be treated as confidential

Please answer all questions. Circle appropriate answer
If returning by email place an x in the appropriate box

Name:______________________________ Date of Birth:______/______/_______

Sport:______________________________. Start Date:______/______/_______

Medical History

1.

Have you ever fainted or passed out when exercising?	Yes	No
Do you ever have chest tightness?	Yes	No
Does running ever cause chest tightness?	Yes	No
Have you ever had chest tightness, cough or wheezing that made it difficult for you to perform in sports?	Yes	No
Do you have trouble breathing or do you cough during or after activity?	Yes	No
Have you ever been dizzy during or after exercise?	Yes	No
Have you ever had chest pain during or after exercise?	Yes	No
Do you have or have you ever had racing of you heart or skipped heartbeats?	Yes	No
Have you ever been told you have a heart murmur?	Yes	No
Do you get tired more quickly than your friends do during exercise?	Yes	No
Have you ever been told you have a heart arrhythmia?	Yes	No
Do you have any other history of heart problems?	Yes	No
If you have answered YES to any of the above please give details:		

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Have you ever had a seizure?	Yes	No
Have you ever been told:-		
You have epilepsy?	Yes	No
To give up sports because of health problems?	Yes	No
You have high blood pressure?	Yes	No
You have high cholesterol?	Yes	No
You have had rheumatic fever?	Yes	No
You have lung disease?	Yes	No
You have diabetes?	Yes	No
You have thyroid disease?	Yes	No
Have you ever been treated/hospitalised for asthma?	Yes	No
Do you have any allergies?	Yes	No
Have you had a severe viral infection (e.g. myocarditis or mononucleosis) within the last month?	Yes	No
Are you taking any medication at the present time?	Yes	No
Have you routinely taken any medication in the past two years?	Yes	No
If you have answered YES to any of the above please give details:		

Have you had to consult with your doctor within the last six months?	Yes	No
If YES, please give details of reasons, which may affect your participation in the test(s)		

Do you currently have any form of muscle or joint injury?	Yes	No
If YES, please give details:		

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Have you had any reason to suspend your normal activity in the past two weeks?	Yes	No
If YES, please give details:		

Family History Has anyone in your family < 50 years of age:		
Died suddenly and unexpectedly?	Yes	No
Being treated for recurrent fainting?	Yes	No
Had unexplained seizure problems?	Yes	No
Had unexplained drowning while swimming?	Yes	No
Had unexplained car accident?	Yes	No
Had heart transplantation?	Yes	No
Had pacemaker or defibrillator implanted?	Yes	No
Had heart surgery?	Yes	No
Experienced sudden infant death (cot death)?	Yes	No
Told they have Marfan Syndrome?	Yes	No
If you have answered YES to any of the above please give details:		

Is there anything to your knowledge that may prevent you from successfully completing the task(s) that have been explained to you?	Yes	No
If YES, please give details:		

Signature of Participant________________________________Date_____/_____/___________

Signature of Test Supervisor____________________________Date_____/_____/___________

Please supply the name, address and telephone number for an emergency contact