

Attachment two

Exercise and Physical Activity Readiness Assessment of Children and Young Adolescents (ExPARA)*

This Exercise and Physical Activity Readiness Assessment (ExPARA) instrument is designed to screen for a wide range of common health-related problems often seen only in children and/or young adolescents.

Centres should develop their own specific exercise prescreen instrument based on the information contained in this ExPARA. Ideally, this instrument should be no more than two A4 pages in length.

Each prescreen instrument should include: a brief statement indicating the purpose of the prescreen, emergency details, medical/health history, parent/guardian informed consent, a disclaimer statement provided by the centre's legal representative and provision for a countersignature by a qualified centre staff member.

Important information for parents/guardians

The purpose of this form is to ensure we provide every child and/or adolescent with the highest level of care.

For most children, physical activity provides an opportunity for children and adolescents to have fun and promotes the basis for good health and an enhanced quality of life for the future.

However, there are a small number of children or adolescents who may be at risk when participating in an exercise/physical activity program. We ask therefore that you read and complete this questionnaire carefully and return it to the appropriate staff member in charge. The information contained in this form is confidential and is subject to the laws and regulations contained in the privacy laws enacted in December 2001.

Personal details

Name: _____ DOB: _____ M/F: _____

Height (cm): _____ Weight (kg): _____ BMI: _____

How old was your child as at 1 January this year? _____

Name/s of parent/s or guardian/s: _____

Home Address: _____

Private home contact ph: _____ Work ph: _____ Mobile: _____

Has a GP or specialist referred your child? _____

Doctor's name: _____ Contact ph: _____

If there is an emergency, specify the person who should be contacted and their emergency phone number:

Name: _____ Contact ph: _____

After hours emergency contact ph: _____

Please note: In case of a medical emergency, an ambulance may be used to transport your child to the nearest medical treatment service.



Heart-Lung-Other systems

1. Does your child have, or has your child had:

- a heart condition (please specify) _____
- Cystic Fibrosis _____
- Diabetes (Type I or Type II – please specify) _____
- High blood pressure (specify when last taken) _____
- High cholesterol _____
- Unexplained coughing during or after exercise _____
- Breathing problems or shortness of breath (for example, asthma, emphysema) _____

2. Does your child experience or has your child ever experienced:

- epilepsy or seizures/convulsions _____

If yes, is it at rest or during exercise?

- fainting
- dizzy spells
- heat stroke/heat-related illness
- increased bleeding tendency/haemophilia
- other (please specify) _____

3. Does your child have, or has your child had, an eating disorder?

- Yes No

4. Does your child take any medications for (please name):

- heart problem _____ epilepsy _____
- diabetes _____ Attention Deficit Disorder (ADD) _____
- asthma, breathing problems _____ allergies _____
- blood pressure _____
- other (please specify) _____

4.1 If your child is taking any medication, please state if there are any side effects experienced as a result of taking this medication: _____



Muscle-Bone system

1. In the last six months, has your child had any muscular pain while exercising?

- Yes
- No

If yes, please explain and indicate where the pain has occurred (eg. 'pain in the back of the right heel' or 'pain on the inside of the right elbow'): _____

1.1 Has a doctor treated this pain?

- Yes
- No

2. In the last six months, has your child experienced joint pain, or pain in the bones?

- Yes
- No

If yes, please explain and indicate where the pain has occurred (eg. 'front of right leg' or 'behind my knee bone'): _____

2.1 Has this joint pain, or pain in the bone been treated by a doctor?

- Yes
- No

2.2 Has your child broken any bones or suffered injury to their bones in the last 12 months?

- Yes
- No

If yes, please explain where and how the break/injury occurred. _____

Brain-Muscle system

1. Does your child have, or has your child had difficulty/problems with any of the following?

- vision
- motor sensory skills
- hearing
- poor balance/instability
- speech/language
- sleep apnoea

2. Has your child ever experienced a brain or spinal injury?

- Yes
- No

3. Does your child experience difficulty in the skill of:

- climbing up stairs
- walking down stairs
- none of the above



Special conditions

1. Does your child use a 'puffer' or 'ventilator' for asthma?

Yes No Not applicable

2. Does your child self-administer insulin for Diabetes?

Yes No Not applicable

3. Does your child have any chronic disability or chronic illness?

Yes No

If yes, please indicate the condition:

Cerebral Palsy Hypermobility
 ADHD Obesity
 Downs Syndrome Intellectual impairment
 Other (please specify): _____

4. Is your child allergic to food, medications, pollens or other allergens or specific environments?

Yes No

If yes, please explain what causes have been identified with this/these allergy/ies: _____

5. Does your child follow a special diet?

Yes No

6. Has your child ever been diagnosed with a nutritional deficiency (such as non-iron deficiency)?

Yes No

If yes, please specify the nutritional deficiency : _____



General health

1. Has your child had surgery in the previous 12 months?

Yes No

2. Are you aware of any medical reason/condition which might prevent your child from participating in an exercise program?

Yes No

If yes, please explain: _____

3. What are your child's favourite hobbies and interests? _____

Informed consent

I hereby acknowledge that:

- The information provided above regarding my child's health is, to the best of my knowledge, correct.
- I will inform you immediately if there are any changes to the information provided above.
- I give permission for my child to commence your physical activity program.

Parent/Guardian signature: _____ Date: _____

Disclaimer: Centres should add a disclaimer clause as recommended by the centre's legal advisers.

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Administration only: Referral to Medical Practitioner

- Child/adolescent has no risk factors >> cleared to participate in physical activity program
- Child/adolescent has one or more Heart-Lung-Other risks >> refer to Medical Practitioner
- Child/adolescent has one or more risks from Muscle-Bone and/or Brain-Muscle systems or Special conditions and General health sections. >> Possibly refer to a Medical Practitioner or appropriate allied health professional**

**Name and title of allied health professional child/adolescent is referred to: _____

Signatures

Parent/Guardian: _____ Fitness professional: _____
Date: _____ Date: _____