evolve FITNESS+WELLBEING

Mum's & Bub's Prenatal Mum's & Bub's Postnatal

The Prenatal and Postnatal classes are designed as low intensity, low impact classes, and are suitable for most pregnant women and new mothers.

SAFETY GUIDELINES

- **This MEDICAL CLEARANCE FORM** is to be completed by your doctor *BEFORE* attending the class. Your instructor needs to know of any health problems you may have. It is also important that you immediately advise your instructor of any changes in your health status.
- **Work at your own pace**. If you cannot continue talking throughout your exercise or if your heart rate feels excessively fast, you are working too hard.
- **Your exercises should not hurt**. If you experience pain or any other unexplained symptoms, stop the exercise and inform your instructor and consult your doctor if necessary.
- **Fluid replacement** is important when you exercise. Have a light snack 1-2 hours before you come to class. Drink water before, during and after class.
- If you are taking medication that may be needed during class please keep it close by and let your instructor know where it is.
- It is important for your health team to monitor blood pressure during pregnancy, therefore your instructor will take you BP prior to each class. If possible, please arrive at least 5min prior to class to allow time for this.

Signs that YOU or YOUR BABY distressed are:

If you experience any of these, cease exercise and consult your Health Professional

♦Excessive kicking	♦Absence of regular foetal movement	♦Fainting
♦Breathlessness	♦Palpitations	♦Sudden sharp pain
♦Excessive uterine contractions	♦Sudden vaginal discharge or bleeding	

MEDICAL CLEARANCE FORM

Please complete this form & hand to your instructor for review BEFORE your first class.

NAME:.....

ADDRESS:.....Post Code.....

PHONE (MOB).....(H).....(W).....

DATE OF BIRTH:.....AGE:.....

OBSTETRICIAN/CLINIC.....PHONE:.....

DOCTOR:.....PHONE:.....

PRENATAL --- DUE DATE:...../...../..... ..... / 40 WEEKS

POSTNATAL --- DATE OF DELIVERY:...../...../.....

Advice:

- You should not exercise so hard that you are breathless and your heartbeat is excessive.
- If pregnant, do not perform exercises lying flat on your back after first trimester.
- Do not exercise when unwell (e.g. virus, infection)
- Drink fluids liberally before, during and after exercises

STATEMENT OF CONSENT

a) I recognise that the instructor/Exercise Physiologist is not able to provide me with medical advice regarding my medical fitness. The above information is used as a guideline to the limitations of my ability to exercise.

b) I understand the above advice and have answered the above questions to the best of my ability.

c) I have received consent from my doctor to attend these pregnancy/postnatal exercise classes.

d) To minimise the risk of incident/injury I have read and will abide by the class guidelines.

Signed .....Date.....

(Please hand this form to your instructor when you attend your first session)

DOCTOR'S CONSENT

I believe that the above person is safe to participate in Prenatal / Postnatal classes.

Notes/Precautions:

……
……
……
……
……

Doctor's Name (print) ……

Clinic ……

Doctor's Signature ……***Date***……

PRENATAL MEDICAL CHECKLIST ---

1. Are you having twins?	Yes / No
2. Is this your first pregnancy?	Yes / No
3. How many previous pregnancies have you had?	0 1 2 3+
4. How many children do you have?	0 1 2 3+
5. Did you have any complications in a previous pregnancy? **If yes, please describe:** …….... …….. …….. …….. ……..	Yes / No
6. During this pregnancy, have you had any of the following: **(please tick)**	
a) Vaginal bleeding or diagnosis of placenta praevia.	Yes / No
b) Loss of any fluid from vagina	Yes / No
c) Severe nausea or vomiting	Yes / No
d) Infection (viral/bacterial)	Yes / No
e) Unexplained abdominal pain	Yes / No
f) Unusual fatigue or lack of energy	Yes / No
g) Severe headaches	Yes / No
h) Visual disturbances	Yes / No
i) Sudden swelling or hands, face or feet	Yes / No
j) Unexplained spells of dizziness or faintness	Yes / No
k) Palpitations or chest pains	Yes / No
l) Absence of foetal movement	Yes / No
m) Insufficient weight gain (1kg per month during 2nd & 3rd trimester)	Yes / No
n) Heart disease	Yes / No
o) Chest condition (e.g. Asthma)	Yes / No
p) Epilepsy	Yes / No
q) Diabetes	Yes / No
r) Back /neck injury or pain	Yes / No
s) Any joint or muscle problem	Yes / No

7. Please list any drugs or medications you are currently taking: …….. …….. …….. …….. ……..	
8. Are you seeing a Health Professional regularly throughout your pregnancy?	Yes / No
9. Do you smoke cigarettes?	Yes / No
10. Do you presently participate in any form of exercise? **If yes, what type of exercise:** …….. …… ……..	Yes / No
11. How often? …….. How long? ……..	

The above information is strictly confidential and current at date presented only. EVOLVE FITNESS + WELLBEING takes no responsibility for any medical changes that may occur during or following exercise program.

POSTNATAL MEDICAL CHECKLIST ---

1. Type of delivery?	Vaginal / Caesarean
2. Were there any complications? **If yes, please describe:** …….. ……..	Yes / No
3. How many previous pregnancies have you had?	0 1 2 3+
4. How many children do you have?	0 1 2 3+
5. Postnatal check-up?	Yes / No
6. Are you experiencing any of the following: **(please tick)**	
a) Loss of any fluid from vagina	Yes / No
b) Vomiting or incontinence	Yes / No
c) Infection (viral/bacterial)	Yes / No
d) Discharge of open wound	Yes / No
e) Lack of energy	Yes / No

f) Severe headaches	Yes / No
g) Visual disturbances	Yes / No
h) Sudden swelling or hands, face or feet	Yes / No
i) Unexplained spells of dizziness or faintness	Yes / No
j) Palpitations or chest pains	Yes / No
k) Skin problems	Yes / No
l) Tinea	Yes / No
m) Heart disease	Yes / No
n) Chest condition (e.g. Asthma)	Yes / No
o) Epilepsy	Yes / No
p) Diabetes	Yes / No
q) Back /neck injury or pain	Yes / No
r) Any joint or muscle problem	Yes / No
7. Please list any drugs or medications you are currently taking: …….. …….. …….. …….. ……..	
8. Do you smoke cigarettes? Give details ……	Yes / No
9. Do you presently participate in any form of exercise? **If yes, what type of exercise:** …….. …… ……..	Yes / No
10. How often? …… How long? ……	

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