

## Membership Form - Pedal Power – Please Complete ALL Sheets

Please use block capitals

| Date |                         |  |  |
|------|-------------------------|--|--|
|      | Adult                   |  |  |
|      | Child                   |  |  |
|      | Family                  |  |  |
|      | Family member 1 details |  |  |
|      | Name                    |  |  |
|      | Date of Birth           |  |  |
|      | Family member 2 details |  |  |
|      | Name                    |  |  |
|      | Date of Birth           |  |  |
|      | Family Member 3 details |  |  |
|      | Name                    |  |  |
|      | Date of Birth           |  |  |
|      | Family member 4 details |  |  |
|      | Name                    |  |  |
|      | Date of Birth           |  |  |

| Name      |  |
|-----------|--|
| Date of   |  |
| Birth     |  |
| Address   |  |
|           |  |
|           |  |
| Postcode  |  |
| Telephone |  |
| Mobile    |  |
| Email     |  |

| Name of support worker or parent.  |  |
|------------------------------------|--|
| Name of support organisation       |  |
| Telephone for main support contact |  |
| Email for main support contact     |  |
| Support Manager                    |  |

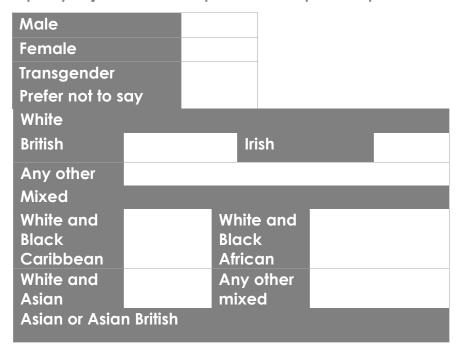
## **Health Questionnaire**

| Have you ever had a heart condition or chest pains?  | Yes | No |
|--|-----|----|
| Do you ever feel dizzy or lose consciousness?        | Yes | No |
| Do you have a bone or joint problem?                 | Yes | No |
| Do you have diabetes?                                | Yes | No |
| Do you have asthma?                                  | Yes | No |
| Do you have epilepsy?                                | Yes | No |
| Are recovering from illness, injury or an operation? | Yes | No |
| Other? Please specify                                | Yes | No |
|  |     |    |

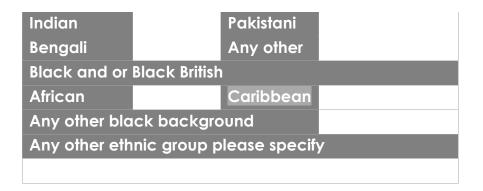
If you have answered yes to any of the above, please check with your GP or health consultant before participating in Pedal Power activities.

## **Equal Opportunities form**

The information you provide will help us to monitor how we are achieving against our Equality objectives and help us to develop and improve our services.



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| Do voi                                 | , have a            | disab | ility       |  |  |  |
|--|---------------------|-------|-------------|--|--|--|
| •                                      |                     |       | illi y      |  |  |  |
| Yes                                    |                     | No    |             |  |  |  |
| Physic                                 | Physical Disability |       |             |  |  |  |
| Learnir                                | Learning Disability |       |             |  |  |  |
| Menta                                  | Mental Health       |       |             |  |  |  |
| Long term health                       |                     |       |             |  |  |  |
| Please tell us what your disability is |                     |       |             |  |  |  |
|  |                     |       |             |  |  |  |
| Do you speak Welsh                     |                     |       |             |  |  |  |
| No                                     | Yes                 |       | A<br>little |  |  |  |
| Preferred language                     |                     |       |             |  |  |  |
|  |                     |       |             |  |  |  |

Staff use only:

| Assessment needed y/n Completed by:_ |  |
|--------------------------------------|--|
| Cycling lessons? y/n with:           |  |