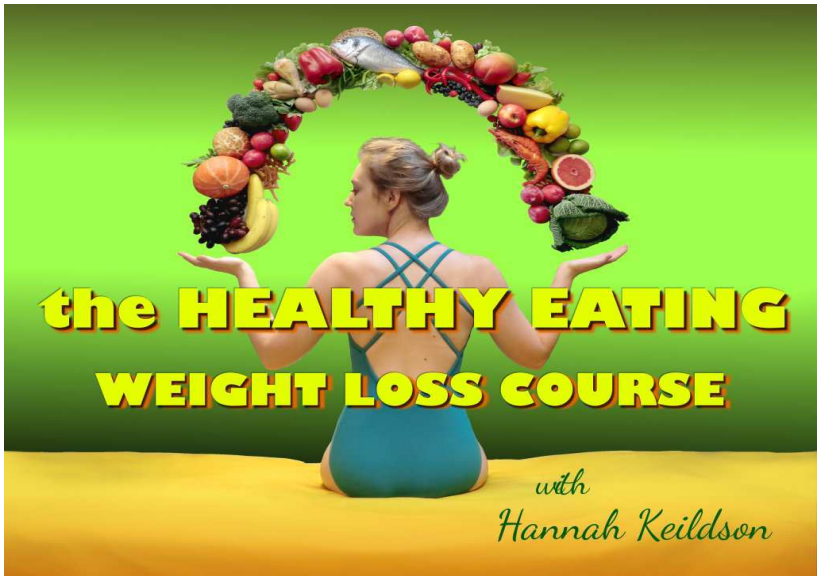

All information is confidential and will not be disclosed to any other persons.

CLASS MORNING / EVENING (RING AS APPROAPRIATE)

NAME……

ADDRESS……

……POST CODE……

PHONE NUMBERS……

E MAIL ADDRESS……

MEDICATIONS……

Please read the following information very carefully and sign if you agree with the terms.

All material included in “The Healthy Eating Weight Loss Course" is provided for your information only and may not be construed as medical advice or instruction. No action or inaction should be taken based solely on the information given in this course and students/attendants should consult their doctor before embarking on the program. Furthermore, if you are on any medication you must consult your doctor or health care professional before taking any supplements recommended.

Signed……Date……..

START DATE.....

START WEIGHT.....

HEIGHT.....

START MEASUREMENTS CHEST..... WAIST ..... HIPS.....

EXERCISE PLAN.....

6 WEEK TARGET WEIGHT.....

6 WEEK TARGET EVENT.....

Please state

if you have special dietary needs (eg vegetarian, allergies, kosher, etc)

if you have any of the following conditions

Diabetes	☐	High cholesterol	☐
Under-active thyroid	☐	High blood pressure	☐
Polycystic ovaries	☐	Water retention	☐
Irritable Bowel Syndrome	☐		

if you share your meals with children ☐

if you mostly cook from scratch ☐

if you predominantly eat ready-made meals ☐

FOR OFFICE USE ONLY

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	DATE	EXERCISED	HOME WEIGHT	COURSE WEIGHT	CHANGE	WEEK GOAL WGT
WEEK 1						
WEEK 2						
WEEK 3						
WEEK 4						
WEEK 5						
WEEK 6						

NEW MEASUREMENTS CHEST..... WAIST ..... HIPS.....