

Twin Cities Minor Tackle Football Association Player Medical Information Form



Date: _____

Player Name: _____

Parent / Guardian Name: _____

Please circle the appropriate response below regarding your child:

- Yes No Previous history of concussions
- Yes No Fainting episode(s) during exercise or sports activity
- Yes No Epileptic
- Yes No Wears glasses
- Yes No If yes, are lenses shatterproof?
- Yes No Wears contact lenses
- Yes No Wears dental appliance
- Yes No Hearing problem
- Yes No Asthma
- Yes No Trouble breathing during exercise or sports activity
- Yes No Heart Condition
- Yes No Diabetic
- Yes No Has had an illness lasting more than one week in the past year
- Yes No Currently taking medication
- Yes No Allergies
- Yes No If yes, do they have an Epi-Pen?
- Yes No Wears a medic alert bracelet
- Yes No Surgery in the last year
- Yes No Has been in the hospital in the last year
- Yes No Has had injury requiring medical attention in the past year
- Yes No Presently injured

Yes No Does your child have any health problem that would interfere with participation on a football team?

Par-Q & You, Health Canada Questions

- Yes No Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
- Yes No Do you feel pain in your chest when you do physical activity?
- Yes No In the past month, have you had chest pain when you were not doing physical activity?
- Yes No Do you lose your balance because of dizziness or do you ever lose consciousness?
- Yes No Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?
- Yes No Is your doctor currently prescribing drugs for your blood pressure or heart condition?
- Yes No Do you know of any other reason why you should not do physical activity?

Please give details below if you answered "Yes" to any question above, or please describe any information that is not covered in this questionnaire.
