

# Spruce Grove & District Minor Football Association Player Medical Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

Parent/Guardian Phone #s: \_\_\_\_\_

### Emergency Contact Person Other Than Parents:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please select the correct answers below for your child:

Has had a concussion	Yes	No	Any other health condition which may present a challenge to his/her physical participation	Yes	No
Has/had epilepsy/seizures	Yes	No	Has fainted during exercise	Yes	No
Wears contacts	Yes	No	Wears glasses	Yes	No
Wears hearing aid or has hearing problem	Yes	No	Wears dental appliance	Yes	No
Has asthma; uses an inhaler	Yes	No	Has diabetes	Yes	No
Carries inhaler on person	Yes	No	Has allergy(s); has an epi-pen	Yes	No
Trouble breathing during exercise	Yes	No	Carries epi-pen on person	Yes	No
Currently on regular medication	Yes	No	Has a heart condition	Yes	No
Presently injured	Yes	No	Wears a medic alert	Yes	No
Serious injury or illness in past 12 months	Yes	No	Surgery in past 12 months	Yes	No
Suffer migraines and or headaches	Yes	No			

If Yes to any questions above, please give details (Use back of form if more room is needed):

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I understand that it is my responsibility to keep team management advised of any changes to the above information as soon as possible. I agree that if no-one listed here can be contacted, team management will take my child to hospital/MD if deemed necessary.

I hereby authorize the physician and nursing staff to undertake examination, investigation and necessary treatment of my child. I also authorize release of information to appropriate people (coaches, physician) as deemed necessary.

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_

Reset