TRI-COUNTY MIDGET FOOTBALL LEAGUE

SECTION 1: NAME AND DOB *PARENT TO COMPLETE THIS SECTION*

NAME OF ATHLETE: _____ BIRTH DATE: _____

SECTION 2: HEALTH HISTORY *PARENT TO COMPLETE THIS SECTION*

CURRENT PROBLEMS	YES	NO
Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident or SIDS)?		
Have you ever passed out or nearly passed out DURING or AFTER exercise?		
Have you ever had intense discomfort, pain, tightness, or pressure in your chest during exercise?		
Does your heart ever race or skip beats (irregular beats) during exercise?		
Have you ever had a head injury or concussion?		
Have you ever experienced heat exhaustion or heat stroke?		
Do you or someone in your family have sickle cell trait or disease?		
Do you have asthma?		
Do you have diabetes?		
Are you currently taking any prescribed medications? If yes, list:		

	YES	NO
Do you have any allergies?		
If yes,	**YES**	**NO**
POLLENS		
FOOD		
BEE STINGS		
OTHER (list):		

Does your child have any past or current health issues that would prevent them from actively participating in the TCFL program?	YES	NO

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

SECTION 3: MEDICAL EXAM *DOCTOR TO COMPLETE THIS SECTION*

WEIGHT: _____

	While this exam does not constitute a complete medical exam, it does on this date, on my observations, meet the requirements for participation in the TCFL program.
	The individual examined by me on the date is considered NOT physically qualified to participate in the TCFL program for the following reasons:

Signature: _____ Date: _____

Physician Name: _____

Physician Address: _____