



## Foothills Lacrosse Association (FLA) Medical Questionnaire

Player Information	
Name	
Birth Date	
Home Address	
Primary Phone #	
Health Card #	
Doctors Name & Phone #	
Emergency Contact Name & Relation	
Emergency Contact Phone #	

Player Medical Information					
<i>Please circle the appropriate response</i>					
YES	NO	Condition	YES	NO	Condition
		Previous history of concussion(s)			Injury in the last year
		Fainting during exercise			Wear glasses
		Epilepsy			Wear contact lenses
		Asthma			Wear a dental appliance
		Heart condition			Hearing impairment
		Diabetes			Takes medications
		Any other conditions that would impact their ability to play lacrosse			Allergies
					Wears medical alert bracelet

*Please provide details if you answered "YES" to any of the above questions.*

*Medications: please provide list of current medications and whether or not the athlete will require medications on the bench (i.e. inhalers).*

***Please note that bench staff are unable to administer medications, please speak with the coach/trainer if your player requires assistance.***



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I understand that it is my responsibility to keep the team Coach and Trainer advised of any changes in the above information as soon as possible.

YES       NO

In the event of an emergency, if no one can be contacted, I consent to the team management sending the player to the hospital by ambulance, if necessary?

YES       NO

I authorize the release of information to appropriate people, i.e. Coaches, Trainer(s), manager(s), and physicians/emergency personnel (if required).

YES       NO

Parent/guardian Name: \_\_\_\_\_

Parent/guardian signature: \_\_\_\_\_

Date: \_\_\_\_\_