

2026 Tri-County Midget Football League

SECTION 1: NAME AND DOB	PARENT TO COMPLETE THIS SECTION
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NAME OF ATHLETE: _____ BIRTH DATE: _____

SECTION 2: HEALTH HISTORY	PARENT TO COMPLETE THIS SECTION
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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)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever passed out or nearly passed out DURING or AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had intense discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Does your heart ever race or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced heat exhaustion or heat stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you or someone in your family have sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking any prescribed medications? If yes, list:	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NO
Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
If yes,	YES	NO
POLLENS	<input type="checkbox"/>	<input type="checkbox"/>
FOOD	<input type="checkbox"/>	<input type="checkbox"/>
BEE STINGS	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (list):	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have any past or current health issues that would prevent them from actively participating in the TCFL program?	<input type="checkbox"/>	<input type="checkbox"/>

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: _____
