

QUESTIONNAIRE ON THE STATE OF HEALTH OF A MINOR ATHLETE WITH A VIEW TO OBTAIN OR RENEW A LICENCE FROM A SPORTS FEDERATION OR REGISTRATION FOR A SPORTS COMPETITION AUTHORISED BY A DELEGATED FEDERATION OR ORGANISED BY AN APPROVED FEDERATION, EXCEPT FOR DISCIPLINES WITH SPECIAL CONSTRAINTS

Warning for parents or guardians:

It's preferable that this questionnaire is completed by your child, it's up to you to estimate if he/she is able to do so by him/herself. It's your responsibility to ensure that the questionnaire is completed correctly and to follow the instructions according to the answers given.

<p>Doing sports: it's recommended for everyone. Have you talked to a doctor about this? Did he/she examine you for advice? This questionnaire isn't a test. You answer YES or NO, but there aren't right or wrong answers. You can ask your parents to help you.</p> <p style="text-align: center;">Are you a girl <input type="checkbox"/> a boy <input type="checkbox"/> Your age: _____ years old</p>		
In the last year	YES	NO
Have you been in hospital for a day or several days?	<input type="checkbox"/>	<input type="checkbox"/>
Did you have an operation?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a growth spurt?	<input type="checkbox"/>	<input type="checkbox"/>
Did you lose or gain a lot of weight?	<input type="checkbox"/>	<input type="checkbox"/>
Did you get dizzy during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
Have you fainted or fallen without remembering what happened?	<input type="checkbox"/>	<input type="checkbox"/>
Did you receive one or more high impact shocks that forced you to interrupt a sports session for a while?	<input type="checkbox"/>	<input type="checkbox"/>
Did you find it much harder to breath during an effort than usual?	<input type="checkbox"/>	<input type="checkbox"/>
Did you have a lot of trouble breathing <u>after</u> an effort?	<input type="checkbox"/>	<input type="checkbox"/>
Did you have pain in your chest or palpitations (your heart beating very fast)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you started to take a new medicine on a daily basis and for a longer period of time?	<input type="checkbox"/>	<input type="checkbox"/>
Did you stop doing sport because of a health problem for a month or longer?	<input type="checkbox"/>	<input type="checkbox"/>
Recently (for a period of more than 2 weeks)		
Have you been feeling very tired?	<input type="checkbox"/>	<input type="checkbox"/>
Do you find it difficult to sleep or do you wake up often during the night?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel less hungry? Do you eat less?	<input type="checkbox"/>	<input type="checkbox"/>
Are you sad or worried?	<input type="checkbox"/>	<input type="checkbox"/>
Do you cry more than usual?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel pain or lack of strength because of an injury you have had this year?	<input type="checkbox"/>	<input type="checkbox"/>
Today		
Do you sometimes think about stopping or changing your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Do you think you need to see your doctor to continue your sport?	<input type="checkbox"/>	<input type="checkbox"/>
Is there anything else you would like to report about your health?	<input type="checkbox"/>	<input type="checkbox"/>
Questions for your parents to complete		
Has anyone in your close family had a serious heart or brain disease, or died suddenly before 50 years old?	<input type="checkbox"/>	<input type="checkbox"/>
Are you worried about their weight? Do you think he/she is eating too much or not enough?	<input type="checkbox"/>	<input type="checkbox"/>
Have you missed any of your child's age-appropriate check-ups with the doctor?	<input type="checkbox"/>	<input type="checkbox"/>

**If you answered YES to one or more of the questions, you should see a doctor to be examined and to find out which sport is suitable for you.
At the time of the visit, give him/her this completed questionnaire.**