

HEALTH QUESTIONNAIRE FOR OFFICIALS

1) PERSONAL DATA

FULL NAME						
DATE OF BIRTH				GENDER	MALE	FEMALE
HEIGHT (INCH)				WEIGHT (POUNDS)		
ADDRESS						
E-MAIL						

2) CHRONIC DISEASES HISTORY

DISEASE	YES	SPECIFY	NO	UNDER TREATMENT	
				YES (go to 3)	NO
HEART DISEASE					
DIABETES					
ASTHMA					
ENPHYSEMA OR COPD *					
ARTHRITIS OR OTHER RHEUMATIC DISEASE					
CANCER					
CIBS **					
KIDNEY/BLADER DISEASE					
ALLERGIES					
SKIN DISEASE					
MOTION/PHYSICAL DISABILITY					
OTHER CRONIC CONDITION					

Notes: * Chronic Obstructive Pulmonary Disease. **Chronic Inflammatory Bowel Syndrome

3) MEDICAL TREATMENT

NOTE. PLEASE FILL IN THIS TABLE IF YOU ANSWER YES IN ANY OF THE PREVIOUS QUESTIONS

MEDICINE	DOSAGE
1°	
2°	

DATE

NOTE: This information is confidential, please send this form to the Medical Officer of the Tournament, you have been appointed to. Thank you.