



HEALTH QUESTIONNAIRE - ADULTS (over 18) -

Health questionnaire relating to the state of health of an adult participant registering for a sports competition authorised by a delegated federation or organised by an approved federation, excluding disciplines with particular constraints.

You are: · a female · a male

Your age :.....years old

Please answer the following questions by YES or NO

To this day	YES	NO
1. Has anyone in your family had a severe heart or brain disease, or died suddenly?	·	·
2. Experienced pain in your chest or unusual shortness of breath (i.e., heart beating very quickly)?	·	·
3. Experienced trouble breathing while playing sports?	·	·
4. Experience any discomfort or loss of consciousness while exercising?	·	·
5. Do you have skin issues (naevus, cancer)?	·	·
6. Does playing golf require you to have a medical device or wheelchair?	·	·
7. Do you practice and play speed-golf (golf and running)?	·	·
8. Do you have any other health concerns that would warrant a visit to a doctor?	·	·

In the last 12 months have you:	YES	NO
9. Are you following a long-term medical treatment (this excludes contraceptives and desensitization to allergies)?	▪	▪
10. Stopped playing sports because of a health problem for a duration exceeding 15 consecutive days?	▪	▪
11. Do you have unusual bone, joint or musculotendinous issues?	▪	▪
12. Have you experienced visual impairment or dizziness?	▪	▪
13. Have you benefited from an arthrodesis or prosthesis fitting (Type hip, knee, shoulder)?	▪	▪
14. Do you carry a pacemaker?	▪	▪

If you answered YES to one of more questions:

You must send a medical certificate of less than 6 months attesting of the absence of any contraindication to the practice of golf (in and out of competition). At the time of the medical check-up, give the doctor this completed questionnaire.

If you answered NO to all questions:

This health questionnaire is sufficient. Please note that this document will be asked when you enrol in a ffgolf championship.

I, the undersigned.....

certifies that I have completed the health questionnaire and answered negatively to all the questions.

Date

Signature