All County Conference Junior Football League
HEALTH QUESTIONAIRE AND AUTHORIZATION FORM

PARTICIPANT'S NAME: _____

ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

GUARDIAN'S NAME: _____

ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

CELL PHONE # _____ **HOME PHONE #:** _____

GUARDIAN'S NAME: _____

ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

CELL PHONE # _____ **HOME PHONE #:** _____

IN CASE OF AN EMERGENCY NAME AND PHONE # TO CALL: _____

WITHIN THE PAST YEAR HAS THE PARTICIPANT BEEN TREATED FOR: PLEASE ANSWER THE FOLLOWING QUESTIONS!

	PLEASE CHECK BELOW			PLEASE CHECK BELOW	
ASTHMA	☐ YES	☐ NO	BROKEN BONES	☐ YES	☐ NO
CONCUSSION	☐ YES	☐ NO	NECK INJURY	☐ YES	☐ NO
HERNIA	☐ YES	☐ NO	HEAD INJURY	☐ YES	☐ NO
KNEE INJURY	☐ YES	☐ NO	ALLERGIES	☐ YES	☐ NO
JOINT INJURY	☐ YES	☐ NO	EPILEPTIC SEIZURES	☐ YES	☐ NO
HEAT EXHAUSTION	☐ YES	☐ NO	DIABETES	☐ YES	☐ NO
DIZZINESS	☐ YES	☐ NO	HEART CONDITIONS	☐ YES	☐ NO
FAINTING SPELLS	☐ YES	☐ NO	WEAR EYEGLASSES	☐ YES	☐ NO
SHORTNESS OF BREATH	☐ YES	☐ NO	WEARING CONTACT LENSES	☐ YES	☐ NO

		Medication	Medication Dosage	Frequency of Dosage
TAKING MEDICATION	YES NO			

I AFFIRM THAT THE ABOVE ANSWERS ARE ACCURATE AND REPRESENT AN OVERALL GENERAL STATE OF MY CHILD'S HEALTH. IN THE EVENT OF INJURY TO MY CHILD I HEREBY GIVE THE AMBULANCE ASSOCIATION, ANY LICENSED CARE PROVIDER OR FACILITY, TO TREAT MY CHILD, AND TO DO THAT IS ALL AND ANYTHING THAT IS MEDICALLY NECESSARY FOR THE TREATMENT OF MY CHILD INCLUDING TRANSPORTATION TO THE NEAREST HOSPITAL FOR EMERGENCY TREATMENT AND ANY AND ALL TREATMENT THAT IS NECESSARY.

PARENT /GUARDIAN SIGNATURE: _____ **Date**_____

INSURANCE CARRIER: _____**PLAN**_____ **GROUP #**_____

HOSPITAL OF CHOICE IF NON EMERGGENCY TREATMENT IS NEEDED_____

IN CASE OF EMERGENCY, INJURED PARTY WILL BE TAKEN TO NEAREST HOSPITAL.