



All County Conference Junior Football League HEALTH QUESTIONNAIRE 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 EMERGENCY TREATMENT IS NEEDED _____

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

