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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.**

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