|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **VOLUNTEER’S NAME:** |  | | | | | | | |
|  |  |  |  |  |  |  | | |
| **DATE OF BIRTH:** |  | / |  | / |  |  | | |
|  | DD | / | MM | / | YYYY |  | | |
|  | | | | | | |  |  |
| **Do you or your Parents, if on their insurance, have benefits through their employer?**  (please note employer benefits are primary) | | | | | | | YES | NO |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MEDICAL HISTORY:** | | | | | | | | | | | | | | | | | | |
| Have you ever had any of the following? Please “Highlight” or put an “X” in the corresponding boxes below | | | | | | | | | | | | | | | | | | |
|  | | **Y** | **N** |  | | **Y** | | **N** |  | | **Y** | **N** |  | | **Y** | | | **N** |
| Arthritis | |  |  | Chronic Indigestion | |  | |  | Enlarged Liver/Spleen | |  |  | Gastrointestinal Issue | |  | | |  |
| Chronic Migraines | |  |  | Chronic Headaches | |  | |  | Hernia-Abdom/Inguinal | |  |  | Joint Conditions | |  | | |  |
| Epilepsy convulsive | |  |  | Kidney Stones | |  | |  | Tumors/Growths/Cysts | |  |  | Bone Condition | |  | | |  |
| Asthma | |  |  | Rheumatic Fever | |  | |  | Anxiety Attacks | |  |  | Chicken Pox | |  | | |  |
| Hay Fever or Sinus | |  |  | Heart Disease/Murmur | |  | |  | Frequent Colds | |  |  | Scarlett Fever | |  | | |  |
| Other Allergies | |  |  | High Blood Pressure | |  | |  | Motion/Car Sickness | |  |  | Pneumonia | |  | | |  |
| Eye Difficulties | |  |  | Tuberculosis | |  | |  | Ear/Nose Problems | |  |  | Hepatitis | |  | | |  |
| Respiratory Problem | |  |  | Diabetes | |  | |  | Throat Problems | |  |  | Appendicitis | |  | | |  |
| Frequent Bronchitis | |  |  | Mononucleosis | |  | |  | Chest Tightness | |  |  | Shortness of Breath | |  | | |  |
| Chronic Illness | |  |  | Kidney Disease | |  | |  | Jaundice | |  |  |  | |  | | |  |
|  | |  |  |  | |  | |  |  | |  |  |  | |  | | |  |
| If YES to any of the above, please give details: | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Do you wear: | Glasses | | | Contacts | Both | | N/A | | | Are they worn during athletic participation? | | | | Yes | | | No | |
|  |  | | |  |  | |  | | |  | | | |  | |  | | |
| Please describe any other serious illness, hospitalizations, injuries, deformities not listed above: | | | | | | | | | | | | | | | | | | |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ALLERGIES:** Please “Highlight” or put an “X” the corresponding boxes below | | | | | | | | | | | | | | | | | | | |
|  | **Y** | **N** |  | | **Y** | **N** |  | | | | **Y** | | | **N** |  | | | **Y** | **N** |
| Bee Stings |  |  | Aspirin | |  |  | Grass or Ragweed | | | |  | | |  | Penicillin | | |  |  |
| Iodine or Similar |  |  | Sulfa Drugs | |  |  | Latex Allergies | | | |  | | |  | Anti-inflammatory | | |  |  |
|  |  |  |  | |  |  |  | | | |  | | |  |  | | |  |  |
| Please list any food or other allergies not mentioned above: | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Have you ever suffered from a fracture or dislocation? | | | | | | | | | Yes | | | | No | | | If yes, please explain: | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Any medical conditions which will interfere with athletic participation? | | | | | | | | | Yes | | | | No | | | If yes, please explain: | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Are you currently on any medications, either prescription or over the counter? | | | | | | | | | Yes | | | | No | | | If yes, please explain: | | | |
|  | | | | | | | | |  | | | |  | | |  | | | |
|  | | | | | | | | |  | | | |  | | |  | | | |
| **Concussion History:** | | | | | | | | |  | | | |  | | |  | | | |
| Have you suffered a concussion? | | | | | | | | Yes | No | | | If yes, how many? | | | | |  | | |
| Did you ever have a loss of consciousness due to a concussion? | | | | | | | | Yes | No | | | If yes, how long? | | | | |  | | |
| Have you ever been hospitalized for concussion? | | | | | | | | Yes | No | | | If yes, how long? | | | | |  | | |
| How long were you out/not playing after your last concussion? | | | | | | | |  | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | |
| **EMERGENCY CONTACT:** | | | | | | | |  | | | | | | | | | | | |
| Name: | | | | Relationship: | | | | | | Telephone: | | | | | | | | | |
|  | | | |  | | | | | |  | | | | | | | | | |
| I understand that it is my responsibility to keep the team management advised of any change in the above information as soon as possible and that in the event no one can be contacted, team management will take myself/ my child to the hospital/M.D. if deemed necessary.  I hereby authorize the physician and nursing staff to undertake examination, investigation, and necessary treatment of myself/ my child.  I also authorize release of information to appropriate people (coach, physician etc.) as deemed necessary. | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **Signature of Volunteer OR Parent/ Guardian, if under 18:** | | | | | | | | | | | | **Date:** | | | | | | | |