

Falmouth Youth Football
Health Form – For All Tackle Football Grades 1 – 8 and Cheer Grades 1-12

This document must be filled out by the parent and returned to the Head Coach prior to the beginning of preseason.

HISTORY

Player Name: _____ Sex _____ Age _____ DOB _____

Address _____

Grade (as of Sept 2016) _____ School _____

Personal physician _____ Physician Phone Number _____

In case of emergency, contact:

Name: _____ Relationship _____

Phone (H) _____ (W) _____ (Cell) _____

Explain "Yes" answers on the back of this page. Circle questions you don't know the answers to:

1. Have you had a medical illness or injury since your last check up or physical?
2. Do you have any ongoing or chronic illness?
3. Are you currently taking any prescription or nonprescription (over-the-counter) medications or pills or using an inhaler
4. Do you have any allergies (i.e. pollen, stinging insects, medications)?
5. Have you ever had a rash or hives develop during or after exercise?
6. Have you ever passed out during or after exercise?
7. Have you ever had chest pain during or after exercise?
8. Have you ever been dizzy during or after exercise?
9. Do you get tired more quickly than your friends do during exercise?
10. Have you ever had racing of your heart or skipped heartbeats?
11. Have you had high blood pressure or high cholesterol?
12. Have you ever been told you have a heart murmur?
13. Has any family member or relative died of heart problems or of sudden death before age 50?
14. Have you had a severe viral infection (i.e., myocarditis or mononucleosis) within the last month?
15. Has a physician ever denied or restricted your participation in sports for any heart problem?
16. Do you have any current skin problems (i.e., itching, rashes, acne, warts, fungus or blisters)?

17. Have you ever had a head injury or concussion?
18. Have you ever been knocked out, become unconscious or lost your memory?
19. Have you ever had a seizure?
20. Do you have frequent or severe headaches?
21. Have you ever had numbness or tingling in your arms, hands, legs or feet?
22. Have you ever become ill from exercise in the heat?
23. Do you cough, wheeze or have trouble breathing during or after activity?
24. Do you have asthma?
25. Do you have seasonal allergies that require medical treatment?
26. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position?
27. Have you ever had any problems with your eyes or vision?
28. Do you wear glasses, contacts or protective eyewear?
29. Have you ever had a sprain, strain or swelling after injury?
30. Have you broken or fractured any bones or dislocated any joints?
31. Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?
32. Record the dates of your most recent immunizations for:
Tetanus _____ Measles _____
Hepatitis _____ Chickenpox _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Date: _____

Signature of parent _____ Date _____