Shikellamy Youth Football
and Cheerleading Inc
P.O. Box 355, Sunbury, PA 17801-0355

HEALTH RECORD AND QUESTIONNAIRE

PERSONAL

Date: _____ Sport: _____ Grade: _____

Full Name: _____

Parent/Guardian Name: _____

Address:_____

_____Phone #: _____

Date of Birth: _____ Social Security #: _____

Family Physician: _____

Physician Phone #: _____

Emergency Contact: _____

Emergency Contact Phone #: _____

Insurance Carrier: _____

Policy #: _____

Are You on any Medications? Yes _____ No_____

If so, what and why? _____

Date of your last Tetanus Booster: _____

Are there any other conditions medical personnel should know about or any medications medical personnel need to keep on hand ?_____

_____

_____

_____

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GENERAL

	Yes	No	Explanation
Asthma ----------	_____	_____	_____
Diabetes----------	_____	_____	_____
Heart Problems----------	_____	_____	_____
Murmurs----------	_____	_____	_____
Dizziness----------	_____	_____	_____
Chest Pains----------	_____	_____	_____
Extra Heart Beat----------	_____	_____	_____
Black Outs----------	_____	_____	_____
Rheumatic Fever_----------	_____	_____	_____

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	Yes	No	Explanation
Cancer	_____	_____	_____
Allergies	_____	_____	_____
Medication	_____	_____	_____
Food	_____	_____	_____
Bites	_____	_____	_____
High Blood Pressure	_____	_____	_____
Drug / Alcohol Problems	_____	_____	_____
Cysts or Lumps	_____	_____	_____
Boils	_____	_____	_____
Jock Itch	_____	_____	_____
Athlete's Foot	_____	_____	_____

Do you take any Medications routinely?

_____

_____

_____

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ABDOMINAL - Have you ever had, or now have, any of the following?

	Yes	No	Explanation
Appendicitis	_____	_____	_____
Stomach Trouble	_____	_____	_____
Bleeding from Rectum	_____	_____	_____
Injury to Spleen	_____	_____	_____
Hernia --	_____	_____	_____
Injury to Kidney	_____	_____	_____

Are any of the following paired organs missing or abnormal?
(Please indicate any absence of any organs)

	Yes	No	Explanation
Lungs	_____	_____	_____
Kidneys	_____	_____	_____
Testes	_____	_____	_____

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NEUROLOGICAL - Have you ever had, or now have, any of the following?

	Yes	No	Explanation
Head Injury			
Skull Fracture	_____	_____	_____
Facial Fracture	_____	_____	_____
Concussion	_____	_____	Number?_____ When?_____
Unconsciousness	_____	_____	How long?_____
Neck Injury			
Cervical Fracture	_____	_____	_____
Pinched Nerve	_____	_____	When?_____
Burner / Stinger	_____	_____	When / How many?_____
Frequent Headaches	_____	_____	How often?_____
Seizure Disorder	_____	_____	_____
Nervous Disorder	_____	_____	_____

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DENTAL – Do you have?

	Yes	No	Explanation
Dentist	_____	_____	Who?_____
Cavities	_____	_____	_____
False Teeth	_____	_____	_____
Many Toothaches	_____	_____	_____
Missing Teeth	_____	_____	_____
Pain with Hot or Cold	_____	_____	_____
TMJ Dysfunction	_____	_____	_____

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EAR- NOSE –THROAT - Have you ever had, or now have, any of the following?

	Yes	No	Explanation
Hearing Difficulty	_____	_____	_____
Frequent Earache	_____	_____	_____
Problems Breathing / Chest	_____	_____	_____
Through Nose	_____	_____	_____
Broken Nose	_____	_____	_____
Frequent Tonsil Infection	_____	_____	_____

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ORTHOPAEDIC - - Have you ever had, or now have, any injury to any of the following?
(Please note whether injury was to the left or right side)

	Yes	No	Explanation
Neck	_____	_____	_____
Shoulder	_____	_____	_____
Arm	_____	_____	_____
Elbow	_____	_____	_____
Wrist	_____	_____	_____
Hand	_____	_____	_____
Fingers	_____	_____	_____
Back	_____	_____	_____
Ribs	_____	_____	_____
Hip	_____	_____	_____
Groin	_____	_____	_____
Thigh	_____	_____	_____
Knee	_____	_____	_____
Lower Leg	_____	_____	_____
Ankle	_____	_____	_____
Foot	_____	_____	_____
Other	_____	_____	_____

_____

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Have you in the past or do you now use alcohol, steroids or other drugs?

Yes	No	Explanation
_____	_____	_____

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Please list other health problems, hospitalizations or surgical procedures you have had or undergone.

_____

_____

_____

FAMILY HEALTH HISTORY – Has a member of your family died of or now have any of the following?

	Yes	No	Explanation
Sudden Death	_____	_____	_____
Heart Disease	_____	_____	_____

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Diabetes ---------- _____ _____ _____

High Blood Pressure ---------- _____ _____ _____

Seizure Disorder ---------- _____ _____ _____

FEMALES ONLY -

	Yes	No	Explanation
Have you ever been treated for a Female disorder ----------	_____	_____	_____
Had a change in Menestrual pattern---	_____	_____	_____

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My son / daughter has my/our permission to participate in the following sport: _____

All of the above responses are true and accurate to the best of my/our knowledge.

_____ _____

Parent / Guardian Signature Date

The physical will not be completed until this History Form is completed and signed.
THERE WILL BE NO EXCEPTIONS MADE