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| **Official use only:****Date Received:****……………………………………………****Checked by:****……………………………………………..****ROCHDALE AFC ACADEMY****PARENT(S)/GUARDIAN(S) MEDICAL QUESTIONNAIRE SEASON 2018/19** |
| All questions contained in this questionnaire are strictly confidential and will become part of your sons medical record. |
| Name:  |  |  |  |  |  | **Age Group:**  | DOB:  |  |
| Name of GP:  |  | **Contact Number of GP:**  |
| **Address of GP:**  |
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| History of Previous Illness |
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| **Has your son had any of the following conditions? if so please give as much detail as possible including dates** |
| Heart Conditions | Heart Murmurs [ ] YES [ ] NO | Details:       |
| Any family history of heart disease or sudden cardiac death syndrome before the age of 60 years, in parents, grandparents, uncle, aunt and 1st cousin? (Note Smoking Habits) [ ] YES [ ] NO | Details:       |
| Any family history of high or low blood pressure? [ ] YES [ ] NO | Details:       |
| Any Other (Please Specify) [ ] YES [ ] NO | Details:       |
| Chest Conditions | Asthma [ ] YES [ ] NO (**If answered yes please provide further details in section 3 below**) |  |  |
| Bronchitis [ ] YES [ ] NO | Details:       |  |
| Tuberculosis [ ] YES [ ] NO | Details:       |
| Any Other (Please Specify) [ ] YES [ ] NO | Details:       |
| Eye Conditions | Does your son wear glasses or contact lenses? [ ] YES [ ] NO | Details:       |
| Do they wear them for sporting activity? [ ] YES [ ] NO | Details:       |
| Eye Conditions [ ] YES [ ] NO  | Details:       |
| Ear/Nose/Throat Conditions | Ear Infections [ ] YES [ ] NO  | Details:       |  |  |
| Sinus Problems [ ] YES [ ] NO | Details:       |
| Tonsillitis [ ] YES [ ] NO | Details:       |
| Any Other (Please Specify) [ ] YES [ ] NO | Details:       |  |
| Allergies | Hayfever [ ] YES [ ] NO  | (If answered yes please provide further details in section 3 below) |  |  |
| Food items [ ] YES [ ] NO | (If answered yes please provide further details in section 3 below) |
| Any Other (Please Specify) [ ] YES [ ] NO | (If answered yes please provide further details in section 3 below) |
| Skin Conditions | Eczema [ ] YES [ ] NO | Details:       |  |
| Psoriasis [ ] YES [ ] NO | Details:       |  |
| Dermatitis [ ] YES [ ] NO | Details:       |  |
| Any Other (Please Specify) [ ] YES [ ] NO | Details:       |  |
| Stomach Conditions | Celiac Disease [ ] YES [ ] NO | Details:       |  |  |
| Crohn’s Disease [ ] YES [ ] NO | Details:       |  |  |
| Bowel Obstruction [ ] YES [ ] NO | Details:       |
| Any Other (Please Specify) [ ] YES [ ] NO | Details:       |  |  |
| **Metabolic****Conditions** | Diabetes [ ] YES [ ] NOType (if answered yes above)[ ]  Type 1 [ ] Type 2  | Details:       |  |  |
| Urological Conditions | Urinary Incontinence [ ] YES [ ] NO | Details:       |  |  |
| Any Other (Please Specify) [ ] YES [ ] NO | Details:       |  |  |

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| Medical History |
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| Immunizations and dates:(Please specify dates to give as much background information as possible) | [ ]  Tetanus |  | Date:  | [ ]  Polio | Date:       |  |
| [ ]  Hepatitis |  | Date:       | [ ]  Chickenpox |  | Date:       |
| [ ]  Influenza |  | Date:       | [ ]  MMR Measles, Mumps, Rubella | Date:       |  |
| [ ]  Diphtheria |  | Date:       | [ ]  Whooping Cough |  | Date:       |
| [ ]  Meningitis |  | Date:       | [ ]  Other (Please Specify) | Date:       |  |
| Has your son ever been diagnosed with any of the below infectious diseases? (Please give details below) |
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| Measles [ ]   | Dates: | Rubella [ ]  | Dates: | German Measles [ ]  | Dates: |  |  |  | Glandular Fever [ ]  |
| Mumps [ ]  | Dates: | Chickenpox [ ]  | Dates: | Whooping Cough [ ]  | Dates: |  |  | Other (Specify) [ ]  |

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| Any further Information: |
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|  |
| During the last 12 months has your son missed training/matches or experienced any pain/discomfort following training/matches, which may have been caused by injury to the following joints? (Please give details below)  |
| **Joint** | **Information** | **Date** |
| Feet/Ankle [ ]  |       |       |
| Knee [ ]  |       |       |
| Groin/Hip [ ]  |       |       |
| Back [ ]  |       |       |
| Shoulder [ ]  |       |       |
| Elbow/Hand/Wrist [ ]  |       |       |
| Has your son been under any form of treatment or consultation by a Doctor/Consultant for any medical condition? [ ] YES [ ] NO (If yes please give details below) |
|  |
| **Has your son had any major/serious injuries (including fractures) requiring hospital treatment? YES [ ]  NO** [ ]  (If yes please give details below) |
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| Is your son currently taking any form of medication including vitamins and supplements etc? [ ] YES [ ] NO (Please give details below) |
| **Name of Drug** | **Strength** | **Frequency Taken** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| Does your son have any allergies to medications? [ ] YES [ ] NO (Please give details below) |
| **Name the Drug** | **Reaction You Had** |
|       |       |
|       |       |

**SECTION 3** |
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| Asthma  |
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| What medication is your son taking? | Details:       |  |  |
| How often is the medication required? | Details:       |  |
| What dosage is required per use? | Details:       |  |
| How long since medication was last used? | Details:       |  |
| Is your son under your GP for regular check ups? | Details:       |  |
| Is yours sons asthma seasonal if so when do symptoms occur? | Details:       |  |
| **PLEASE NOTE THAT YOUR SON WILL NOT BE ABLE TO PARTICIPATE IN ACADEMY TRAINING/GAMES UNLESS INHALERS/MEDICATION IS HANDED TO THE COACHES PRIOR TO EACH TRAINING SESSION OR GAME. PLEASE ENSURE ALL MEDICATION IS LABELLED CORRECTLY WITH YOUR SONS NAME ON.** |

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| allergies/hayfever |
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| Does your son take medication for their allergy? [ ] YES [ ] NO |
| What medication do they take? |
| How often do they take this medication? [ ] Daily [ ] When needed [ ] Before sport [ ] Other  |
| Do they require an epipen? [ ] YES [ ] NO |
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| OTHER Conditions |
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| IF YOUR SON HAS HAD ANY FURTHER MEDICAL CONDITIONS NOT LISTED ON THIS FORM PLEASE GIVE DETAILS IN THE BOX BELOW. |

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ROCHDALE AFC ACADEMY SPORTS SCIENCE & MEDICINE DEPARTMENT

Signed: …………………………………………………………………………………

(Parent/Guardian)

Print Name:

…………………………………………………………….....................

(Block Capitals)

Date: ………………………………………………………………………………..