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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:** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| History of Previous Illness | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **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 NO  Type (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 | | | | | | | | | | | |
|  | | | | | | | | | | | |
| 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) | | | | | | | | | | | |
| |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Measles | Dates: | Rubella | Dates: | German Measles | Dates: |  |  |  | Glandular Fever | | Mumps | Dates: | Chickenpox | Dates: | Whooping Cough | Dates: |  | |  | Other (Specify) | | | | | | | | | | | | |
| Any further Information: | | | | | | | | | | | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| 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) | | | | | | | | | | | |
|  | | | | | | | | | | | |
| |  |  |  | | --- | --- | --- | | 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 | | | |
|  | | | |
| 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 |
|  |
| 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 |
|  |
|  |
| OTHER Conditions |
|  |
| 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: ………………………………………………………………………………..