ROCHDALE AFC ACADEMY
PARENT(S)/GUARDIAN(S) MEDICAL OUESTIONNAIRE SEASON 2019/20

All questions contained in this questionnaire are strictly confidential and will become part of your sons medical record.

Official use only:
Date Received:
.....
Checked by:
.....

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:
	Celiac Disease ☐YES ☐NO	Details:

Stomach Conditions	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:

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

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.

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.

Signed:
.....
(Parent/Guardian)

Print Name:
.....
(Block Capitals)

Date:
.....