Fer De Lance Field Hockey Club Health Questionnaire
(To be filled out by Participant's Parent or Guardian)

Participant_____ **Birth date** ____/_____/_____ **Sex: M F**

Address_____ **Phone ( )**_____-_____

Family Physician_____ **Phone ( )**_____-_____

Parent/Guardian_____ **Camp Type**_____

Medications: (Indicate medications that are taken on a regular basis)

Medication Name _____ Dosage_____ Directions_____
Medication Name _____ Dosage_____ Directions_____
Medication Name _____ Dosage_____ Directions_____

Note: Participants should bring an adequate supply of their medication(s) with them.

Explain any "yes" answers below:	**Yes**	**No**
Nervous System: Has the participant ever…		
Had a head injury**?**.....	□	□
Been Knocked out or unconscious?.....	□	□
Had a seizure?.....	□	□
Had a stinger, burner or pinched nerve?.....	□	□
Had any problems with his or her eyes or vision?.....	□	□
Worn glasses, contacts or protective eyewear?.....	□	□
Circulation: Has the participant ever…		
Been dizzy or passed out during or after exercise?.....	□	□
Had chest pain during or after exercise?.....	□	□
Tired out more quickly than their friends during exercise?.....	□	□
Been told he or she has a heart murmur?.....	□	□
Had racing heart or skipped heartbeats?.....	□	□
Had anyone in their family die of heart problems or sudden death before age 50?.....	□	□
Respiratory: Has the participant ever…		
Does the participant ever have trouble breathing or cough during or after exercise?.....	□	□
Musculoskeletal:		
Does he/she frequently have heat or muscle cramps?.....	□	□
Does he/she use any special equipment (pads, braces, neck rolls, etc.)?.....	□	□
Has he/she had any injuries of any bones or joints?.....	□	□
□Head □Chest □Shoulder □Elbow □Wrist □Hip □Knee □Ankle		
□Neck □Back □Forearm □Hand □Thigh □Calf □Foot		
Skin:		
Does he/she have any skin problems (itching, rashes, acne, etc.)?.....	□	□
General:		
Has he/she ever has surgery or been hospitalized?.....	□	□
Has he/she has any other medical problems **?**	□	□
Is he/she taking any medications or pills?.....	□	□
Does he/she have any allergies (medicines, bees, etc.)?.....	□	□
When was the participant's last tetanus shot? _____		
When was the participant's last measles immunization? _____		
Females Only:		
When was the participant's first menstrual period? _____		
When was the participant's last menstrual period? _____		

I hereby state that, to the best of my knowledge, my answers to the above questions are correct. I as parent/guardian, also consent to the examination of the Participant. Any abnormalities will be referred to the Participant's personal physician or appropriate specialist physician.

Signature of Participant _____ Date _____

Signature of Parent/Guardian _____ Date _____

HEALTH INSURANCE INFORMATION SHEET

EVERY PARTICIPANT MUST HAVE THIS FORM ON FILE

Private insurance information must be provided, if applicable. Please be advised that, should a participant require medical attention, **you are responsible for paying any costs not covered by insurance**.

Participant Name _____

Participant's Address _____

Participant's Phone Number _____ Date of Birth _____

Insurance Company Name _____ Effective Date _____

Address of Insurance Company _____

Phone # of Insurance Company _____ Group # _____

Policyholder's Name _____ Policy # _____

Policyholder's Address _____

Relationship to Participant _____ Contract # _____ Employee # _____

I hereby authorize the release of any medical information which might be needed in connection with payment for medical services.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

I request that payment under my medical insurance program be made directly to the provider on any bills for services rendered by that provider. I understand that I am financially responsible for all costs not paid by my medical insurance program.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

EMERGENCY INFORMATION AND CONTACTS

Please complete this form in its entirety. This form will be helpful in the unlikely event of an accident or sudden illness.

Name of Personal Physician _____ Phone # _____

Physician Address _____

Person(s) to contact in case of an emergency:

Name _____ Relationship _____
Address _____
Daytime Phone _____ Evening Phone _____ Cell Phone _____

Name _____ Relationship _____
Address _____
Daytime Phone _____ Evening Phone _____ Cell Phone _____