

UWRF FOOTBALL CAMP HEALTH HISTORY QUESTIONNAIRE

PARTICIPANTS MUST HAVE HAD A PHYSICAL EXAMINATION WITHIN 36 MONTHS OF THE CAMP IN ORDER TO PARTICIPATE. PLEASE FURNISH DATE OF THE LAST PHYSICAL EXAMINATION: ____/____/____

PARTICIPANT: _____
LAST FIRST MIDDLE INITIAL CAMP ATTENDING

HOMEADDRESS: _____
STREET CITY STATE ZIP

DATE OF BIRTH _____ SEX F M HEIGHT _____ WEIGHT _____

PARENT/GUARDIAN _____ RELATIONSHIP _____

HOME PHONE: () - _____ WORK PHONE: () - _____
ADDRESS IF DIFFERENT FROM ABOVE: _____

IN CASE OF EMERGENCY (INJURY OR ILLNESS) IF PARENTS OR GUARDIANS ARE UNABLE TO BE CONTACTED, WHO SHOULD WE CONTACT?

(1) NAME: _____ RELATIONSHIP _____ PHONE _____
(2) NAME: _____ RELATIONSHIP _____ PHONE _____

NAME OF PHYSICIAN: _____ PHONE: _____

INSURANCE COMPANY: _____ ADDRESS _____
POLICY # _____ PHONE # _____

IMMUNIZATION RECORD:
*MMR (MEASLES, MUMPS, RUBELLA) DOSE #1 ____/____/____ DOSE #2 ____/____/____
*TETANUS-DIPHTHERIA YEAR OF INITIAL SERIES ____/____/____ BOOSTER ____/____/____

HAVE YOU EVER HAD MAJOR SURGERY OR BEEN HOSPITALIZED? ___ YES ___ NO
Please explain any significant operations, accidents or illnesses, and last medical attention and reason:

DOES THE PARTICIPANT HAVE ANY MEDICAL/PHYSICAL CONDITIONS OR LIMITATIONS REQUIRING SPECIAL CONSIDERATIONS:
EXPLAIN _____

DOES PARTICIPANT HAVE ALLERGIC REACTIONS TO:

YES	NO		IDENTIFY
___	___	PENICILLIN	_____
___	___	OTHER ANTIBIOTICS	_____
___	___	OTHER MEDICINES (TYPE)	_____
___	___	INSECT BITES/STINGS	_____

ARE YOU TAKING ANY PERScription OR OVER THE COUNTER MEDICATIONS REGULARLY? ___ YES ___ NO
IF YES, IDENTIFY _____

HAS PARTICIPANT HAD OR PRESENTLY EXPERIENCING:

YES	NO		YES	NO	
___	___	ALLERGIES	___	___	HIGH BLOOD PRESSURE
___	___	ASTHMA	___	___	JOINT INJURY/SURGERY
___	___	BLEEDING DISORDER	___	___	KIDNEY DISEASE
___	___	CANCER	___	___	MENSTRUAL DIFFICULTIES
___	___	COLITIS	___	___	MENTAL/EMOTIONAL PROBLEMS
___	___	DIABETES	___	___	NECK/BACK PAIN/INJURY
___	___	EPILEPSY/SEIZURES/BLACKOUTS	___	___	RHUEMATIC FEVER
___	___	HEART DISEASE	___	___	TUBERCULOSIS
___	___	HERNIA	___	___	ULCER

OTHER: _____