SAN RAMON VALLEY THUNDERBIRD FOOTBALL & CHEER PROGRAM
VOLUNTARY PARTICIPANT EMERGENCY HEALTH QUESTIONNAIRE

To facilitate effective and expedient care of previously known medical conditions pertaining to your child that may arise during the course of physical activities during practice and game events, you are asked to *voluntarily* provide any relevant information in the space below. There are many medical conditions that may not prevent a child participating in the program, but may arise during the course of program activities. Often coaches and medical personnel can best respond with first aid to medical symptoms if they have an awareness of any preexisting conditions that require special handling. For instance during strenuous exercise, a participant may develop acute asthmatic symptoms that require the use of a specific inhaler agent to arrest the problem. The parent could make available the child's inhaler medication (labeled with the participant's name, specific instructions for use, and dosage) at practice and during games so it may be administered swiftly.

This information is to remain confidential among program coaches and attending medical personnel. This solicitation is in no way mandatory, and is to be provided on a voluntary basis by the child's parent or guardian. The sole purpose of this questionnaire is to better prepare for medical emergencies. Providing, or not providing, this information is not to bias factors associated with the selection of the child for participation in the program. *If you choose to not provide any information, please indicate below and return the form with only the participant's name, program level, parent/guardian name, date, and signature.*

Participant Name: _____ **Circle:** Cheer Football

Year: _____ **Circle Program Level:** Scout Jr. Pee Wee Pee Wee Jr. Midget Midget

Please indicate any medical conditions you feel would benefit from advance knowledge by coaches and medical personnel to better attend to your child during T-Bird program activities:

___ None
___ Allergies
___ Asthma
___ Bee Sting Hypersensitivity
___ Foot Problems
___ Gastrointestinal Problems
___ Hay Fever
___ Seizures
___ Other_____

Additional detail information pertaining to the above condition(s):_____

Are there any specific medications or inhaler agents that should be present at our program activities? Please also designate specific instructions for use, dosages, etc. _____

If NOT providing medical information-- please circle → : MEDICAL INFORMATION WITHHELD
and fill-in only participant's name, parent/guardian name, date, and signature as an acknowledgment that you choose not to provide medical information.

Parent/Guardian Name _____ **Signature** _____ **Date** _____

Emergency Contact Phone number(s):_____