JOX SPORTS HEALTH QUESTIONNAIRE

Childs Name:_____

Birth Date (D)_____/(M)_____/(Y)_____

Please answer the following questions to the best of your ability with a YES or NO

1. In the last year, has a doctor restricted your child's participation in sports for any reason without clearing your child to return to sports?

2. In the last year, does your child get light-headed or feel shortness of breath more than expected during exercise?

3. In the last year, has your child had an unexplained seizure?

4.In the last year, has your child had a head injury or concussion that still has symptoms like continuing headaches, concentration problems or memory problems?

5.In the last year, has your child had numbness, tingling, weakness in, or inability to move their arms or legs after being hit or falling?.

Parents or Legal Guardians: Please note any health concerns, medications, or allergies that may be important for the coaches or athletic/activities director to know.

*I do not know of any existing physical or additional health reason that would preclude participation in sports. I certify that the answers to the above questions are true and accurate and I approve participation in athletic activities

x_____

Parent or Legal Guardian Signature