US Youth Soccer Olympic Development Program

Proud Member of the U.S. Soccer Federation, Inc.

ODP Medical History Questionnaire

NAME ____
LAST FIRST MIDDLE

ADDRESS ____
STREET CITY STATE ZIP

DATE OF BIRTH____________EMERGENCY CONTACT__________________________PHONE ( ) -

PLEASE CIRCLE "YES" OR "NO" AND PROVIDE ADDITIONAL DETAILS WHERE REQUESTED ON BOTH SIDES OF THIS FORM. ALL INFORMATION WILL BE CONFIDENTIAL.

1. Are you allergic to any medication (aspirin, penicillin, sulfa, etc.)? NO YES
   List: ____________________
2. Do you take any prescribed medication on a permanent or semi-permanent basis (steroids, birth control Pills, anti-inflammatories, antibiotics, etc.)? List & give reason:____________________ NO YES
3. Have you ever had an epileptic seizure? NO YES
4. Have you ever been told by a doctor that you have epilepsy? List medication: ____________ NO YES
5. Have you ever been treated for diabetes? NO YES
6. Have you ever been told by a doctor that you were anemic? When?____________ NO YES
7. Have you ever been told by a doctor that you have sickle cell anemia? NO YES
8. Have you ever been told by a doctor that you have sickle cell trait? NO YES
9. Do you have or have you ever had high blood pressure? List medication:____________ NO YES
10. Do you have or have you ever had the following diseases?
    - Heart disease (heart murmur, rheumatic fever) Give date: ____________ NO YES
    - Lung disease (pneumonia) Give date: ____________ NO YES
    - Kidney disease (infections) Give date: ____________ NO YES
    - Liver disease (mononucleosis, hepatitis) Give date: ____________ NO YES
11. Do you or have you ever been told by a doctor that you have asthma? List medications: ____________ NO YES
12. Do you or have you ever had a hernia or "rupture"? NO YES Has it been repaired? NO YES
13. Have you been "knocked out" (unconscious) in the past 3 years? List dates: ____________ NO YES
14. Have you had a concussion or other head injury in the past 3 years? List dates: ____________ NO YES
15. Have you stayed overnight in a hospital due to a head injury? List dates: ____________ NO YES
16. Have you ever had a neck injury involving bones, nerves or discs that disabled you for a week or longer? NO YES
    Type of injury ____________________Dates: ____________
17. Do you wear glasses or contacts during competition? NO YES
18. Do you wear any of the following dental appliances: (circle those which apply)
    PERMANENT BRIDGE, BRACES, REMOVABLE RETAINER, PERMANENT RETAINER, REMOVABLE PARTIAL PLATE, FULL PLATE, PERMANENT CROWN OR JACKET?
19. Have you had a broken bone or fracture in the past 2 years? R or L What bone?________ Dates: ____________ NO YES
20. Have you had a shoulder injury in the past 2 years that disabled you for a week or longer (Dislocation, separation, etc.) R or L Type of injury:________________Dates: ____________ NO YES
21. Have you ever had shoulder surgery? NO YES
    R or L What was done & why? ____________________ Date: ____________
22. Have you ever injured your back? Type of injury:____________________ Date:____________ NO YES
23. Do you have back pain? (Circle those, which apply) NO YES
    SELDOM, OCCASIONALLY, FREQUENTLY, WITH VIGOROUS EXERCISE, WITH HEAVY LIFTING
24. Have you injured your knee in the past 2 years? R or L What was done & why?_________ Date:__________ NO YES
25. Have you been told by a doctor or athletic trainer that you injured the cartilage in your knee? R or L Date_____ NO YES
26. Have you been told by a doctor or athletic trainer that you injured the ligaments in your knee? R or L Date_____ NO YES
27. Have you ever had knee surgery? R or L What was done & why?____________ Date:____________ NO YES
28. Have you had severe ankle sprain in the past 2 years? NO YES
29. Do you have a pin, screw, or plate in your body? Where in your body? ____________ Date:____________ NO YES
30. Do you have any other conditions that we should be aware of (i.e. ulcers, pregnancy, food or insect Allergies, tendonitis, etc.)? Specify & give details: ____________________ NO YES
31. Please give the date of your last immunization for: tetanus polio mumps rubella measles Date: ____________

THE QUESTIONS ON THIS FORM HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.

____________________	____________	____________________	____________
SIGNATURE OF PARENT/GUARDIAN	DATE	SIGNATURE OF PLAYER	DATE