**Wrestler name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MNUSA ID: \_\_\_\_\_\_\_\_\_\_\_ Insurance Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_Policy#: \_\_\_\_\_\_\_\_\_\_**

**NRHEG Panther Youth Wrestling Club** **Medical questionnaire**

**(Please Circle Yes or No. All information will be confidential)**

**Yes No 1. Are you allergic to any general medications (aspirin, sulfa, penicillin, etc.)? If so, please indicate the name of medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No 2. Are you now on any prescription medication on a permanent or semi-permanent basis?**

**If so, please indicate the name of the medication and why prescribed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No 3. Have you ever had an epileptic seizure or been informed that you might have epilepsy?**

**Yes No 4. Have you ever been treated for diabetes?**

**If so, please indicate type of medication:**

**Yes No 5. Has a medical doctor ever told you that you were anemic or had sickle cell anemia?**

**Yes No 6. Do you have or have ever had high blood pressure?**

**Yes No 7. Do you have or have you ever had any of the following diseases? If so, please circle the appropriate ones(s) Heart disease (Rheumatic fever) Liver disease (Hepatitis)Kidney disease (infections)Lung disease (Pneumonia)**

**Yes No 8. Have you ever been informed by a medical doctor that you have asthma? If so, what medications, if any do you take regularly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No 9. Do you have an unrepaired hernia?**

**Yes No 10. Have you ever been “knocked out” or experienced a concussion during the last 3 years? If so, did the attending physician have you stay overnight in the hospital? Dates\_\_\_\_\_\_\_\_\_\_\_**

**Yes No 11. Have you ever had an injury to your neck involving nerves, vertebrae, or discs that incapacitated you?**

**Yes No 12. Do you wear any dental appliance? If yes, circle the appropriate one(s):**

**Permanent Bridge Permanent Crown or Jacket Brace, Full Plate Removable Partial Plate Permanent Retainer**

**Yes No 13. Do you wear contact lenses during completion?**

**Yes No 14. Have you had a fracture during the past 2 years?**

**If so, please indicate which bone(s) were broken \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Yes No 15. Have you ever had a shoulder dislocation or other shoulder injuries in the past 2 years?**

**Yes No 16. Have you ever had surgery to correct a shoulder condition? If so, please give dates(s)**