UPDATE FORM FOR SPORTS TRYOUTS. REQUIRED FOR ALL

Date of last Physical _____ Date of last Tetanus _____

STUDENT NAME _____
(LAST) (FIRST) (MI)

_____
(STREET ADDRESS) (CITY) (STATE) (ZIP) (PHONE)

DATE OF BIRTH ____/____/____ AGE _____ GRADE 9 10 11 12 (CIRCLE ONE) Sport _____

Mother's Name _____ **Father's Name** _____

Medical History

MUST BE COMPLETED BY PARENT ANSWER ALL QUESTIONS INCOMPLETE FORMS WILL BE RETURNED

HAS STUDENT EVER EXPERIENCED :	NO	YES	Dates ALL YES ANSWERS MUST BE EXPLAINED
ALLERGIES			
Asthma /Reactive Airway/ Any Breathing Problems			
Blood Disorders/Nose Bleeds			
Cancer			
Chicken Pox			
Diabetes			
Headaches/ Concussion/ Unconsciousness/Memory Loss/ Head Blow/Black Outs			
Hearing Problems/Hearing Aid			
Heart Disease/Problems with exercise			
Hepatitis			
Hi/Lo Blood Pressure/Fainting			
Hospitalizations/Infections/ER Visits			
Kidney /Urinary Tract Problem			
Medication Reactions			
Menstrual Disorder			
Mononucleosis/Fatigue/Tiredness			
Muscular Disorder/Ligament/ Tendon Damage/Injury/Sprains			
Orthopedic Disorder/ Broken Bones			
Chest Pain/Racing Heart			
Scoliosis			
Seizure Disorder			
Strep Infections			
Surgery/Outpatient Procedures/Tests			
Ulcer/Gastrointestinal Disorder			
Visual Problems/Glasses/Contact Lenses			
Other			

Since the last physical has there been any incident of Heart Attack/Heart Trouble in a family member under 50 years Of age? ___N ___Y Any Incident of Sudden Death of a Family Member ? ___ N ___ Y

Does student take any medication on a regular basis? ____N ___ Y Name of Medication _____

Recently stopped a medication? ____N ____Y Name of Medication _____

Has the student ever been advised by a physician not to play a sport? ____ N ____Y Reason _____

PARENT SIGNATURE STUDENT SIGNATURE DATE

STUDENT CONTACT INFORMATION

Student Name _____ Current Grade _____

Address _____ Town _____

Home # _____ Student Cell # _____ Student E Mail _____

Father's Name _____ Home # _____

Place of Business _____ Work # _____

E MAIL _____ Cell # _____

Mother's Name _____ Home # _____

Place of Business _____ Work # _____

E MAIL _____ Cell # _____

EMERGENCY CONTACTS

1. _____ Tel # _____

Relationship _____

2. _____ Tel # _____

Relationship _____

EMERGENCY MEDICAL INFORMATION

Allergies : NO _____ YES _____ TYPE: _____

EMERGENCY MEDICATION : NO _____ YES _____ TYPE : _____

Daily medication : NO _____ YES _____

Asthma : NO _____ YES _____ MEDS : _____

Other : _____

Insurance Co. _____ Policy # _____

THIS INFORMATION WILL BE SHARED WITH ALL APPROPRIATE SCHOOL PERSONNEL AS NEEDED.

Parent Signature _____ Student Signature _____

Date _____

New Jersey Department of Education
Health History Update Questionnaire

Name of School: _____

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student's parent or guardian.

Student: _____ Age: _____ Grade: _____

Date of Last Physical Examination: _____ Sport: _____

Since the last pre-participation physical examination, has your son/daughter:

1. Been medically advised not to participate in a sport? Yes ☐ No ☐
   If yes, describe in detail:
2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes ☐ No ☐
   If yes, explain in detail:
3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes ☐ No ☐
   If yes, describe in detail.
4. Fainted or "blacked out?" Yes ☐ No ☐
   If yes, was this during or immediately after exercise?
5. Experienced chest pains, shortness of breath or "racing heart?" Yes ☐ No ☐
   If yes, explain
6. Has there been a recent history of fatigue and unusual tiredness? Yes ☐ No ☐
7. Been hospitalized or had to go to the emergency room? Yes ☐ No ☐
   If yes, explain in detail
8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes ☐ No ☐
9. Started or stopped taking any over-the-counter or prescribed medications? Yes ☐ No ☐
10. Been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

    If diagnosed with Coronavirus (COVID-19), was your son/daughter symptomatic? Yes ☐ No ☐

    If diagnosed with Coronavirus (COVID-19), was your son/daughter hospitalized? Yes ☐ No ☐
11. Has any member of the student-athlete's household been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

Date: _____ Signature of parent/guardian: _____

Please Return Completed Form to the School Nurse's Office