HEALTH HISTORY UPDATE QUESTIONNAIRE

Name of School: Montgomery Township School District

Student: ____________________________ School Year: ________________

Age: _______________ Grade: _______________ Sport: __________________

Since your son or daughter’s last participation on a Montgomery Township School District sponsored sports team, has the student:

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 joint? 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. Has there been a recent history of Mono within the last four weeks? Yes_____No_____

8. Has there been a sudden death in the family? Yes_____No_____

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9. Has any member of the family under age 50 had a heart attack or “heart trouble” Yes____No____
   If yes explain: ____________________________________________________________
   ____________________________________________________________

10. Been hospitalized or had to go to the emergency room? Yes____No____
    If yes, explain in detail: _______________________________________________________ 
    ____________________________________________________________

11. Have they started/stopped taking any over-the-counter or prescription medications? Yes____No____
    If yes, name of medication(s): __________________________________________________
    ____________________________________________________________

12. Have they ever had, or do they currently have:
   a. A chronic or ongoing illness such as diabetes or asthma? Yes____No____
      If yes, please explain: ______________________________________________________
      ____________________________________________________________
      List name of medication or inhaler: ____________________________________________
   b. Any allergies to bee stings, foods, pollen or latex? Yes____No____
      If yes, please check type of reaction    Rash _____Hives _____ Anaphylactic Reaction _____
      Or other ________________________________________________________________
   c. Do they use an Epi-Pen? Yes____No____
      If yes, please explain: ______________________________________________________

13. Have they had an organ transplant? Yes____No____
    If yes, explain: ____________________________________________________________
    ____________________________________________________________

14. Is there any medical information that should be shared with the School Nurse? Yes____No____
    If yes, explain: ____________________________________________________________
    ____________________________________________________________

Parent/Guardian completing this form (please print): ____________________________________________________________

Signature of parent/guardian: ____________________________ Date: ____________________