Date of Last Physical (Office use only): _____

State of New Jersey
Department of Education

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_____

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: _____