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____

9. Started or stopped taking any over-the-counter or prescribed medications? Yes____ No____
   If yes, name of medication(s) __________________________________________________________

Date:________________________Signature of parent/guardian ___________________________________________

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSES’ OFFICE