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