

**New Jersey Department of Education
ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM**

**MAYBE ONLY BE COMPLETED IF YOU HAVE COMPLETED THE LONG FORM
IN THIS YEARS FALL OR WINTER SPORT SEASON**

Part A: SHORT FORM HEALTH HISTORY QUESTIONNAIRE

Completed by the parent and student and reviewed by examining provider

Today's Date: _____ Date of Last Sports Physical: _____

Student's Name: _____ Sex: M F Age: ___ Grade: ___ Home Phone # _____

Date of Birth: ___/___/___ School: Warren Middle School District: Warren Township

Sport (s): Basketball, Track, Softball, Baseball, Cheerleading (Circle one that applies)

Provider's Name (Medical Home): _____ Phone: _____ Fax: _____

Emergency Contact Information

Mother/Guardian's Name: _____ Cell # _____ Work# _____	Father's/Guardian's Name: _____ Cell # _____ Work# _____
Additional Emergency Contact: _____ Relationship to Student: _____	Cell # _____ Home# _____

Health History Information

Directions: Please answer the following questions about the student's medical history by CHECKING OFF the correct response.

Please answer the following questions.

Has your child had any:

▶ hospitalizations, operations, or illness since the date of the last sports physical?	No	Yes
▪ Please list date(s) and reason		
▶ injuries , which required medical treatment or an excuse from physical education class since the date of the last sports physical?	No	Yes
▪ Please list date(s) and nature of injury		
▶ received care from a medical provider since last sports physical?	No	Yes
▪ Please list date(s) and reason		
▶ medications prescribed since the date of the last sports physical	No	Yes
▪ list current medications, dosage and reason for the medications		
Medication: _____	Dosage: _____	Rationale: _____
Medication: _____	Dosage: _____	Rationale: _____
▶ food, drug or environmental allergies	No	Yes
Allergens: _____		
Medication: Epinephrine Auto Injector	Dosage: 0.3 mg	No Yes
▶ Current Asthma medications	No	Yes
Medication: _____	Dosage: 2 puffs	Rationale: allergy or exercise induced Circle one
▶ diagnosed concussion in last 365 days	No	Yes

Parent Signature: _____ Date: _____

All items negative/ School Nurse approved:	
School MD approved:	
NOT approved Reason:	
School Physician signature/stamp:	