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

Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the parent and student and reviewed by examining provider
Part B: PHYSICAL EVALUATION FORM-Completed by examining licensed provider with MD, DO, APN or PA

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date:____________________ **Date of Last Sports Physical:** ____________________________

Student's Name: ____________________________________ Sex: M F (circle one) Age: ____ Grade: ________

Date of Birth: ____/___/______ School: ______________________________ District: _______________________

Sport(s): ____ Home Phone: (_____) __________

Provider Name (Medical Home): _________________________________ Phone: _________________________ Fax: _____________

EMERGENCY CONTACT INFORMATION

Name of parent/guardian: ___________________________________ Relationship to student: _______________________________

Phone (work): ______________________ Phone (home):_________________________________ Phone (cell): _________________

Additional emergency contact: ______________________________ Relationship to student: _______________________________

Phone (work): ______________________ Phone (home):_________________________________ Phone (cell): _________________

Directions: Please answer the following questions about the student's medical history by CIRCLING the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. **Have you ever had, or do you currently have:**
   a. Restriction from sports for a health related problem? Y / N / Don't Know
   b. An injury or illness since your last exam? Y / N / Don't Know
   c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know
      (1.) An inhaler or other prescription medicine to control asthma? Y / N / Don't Know
   d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know
   e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
   f. Any **allergies** to medications? **Y / N / Don't Know**
   g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't Know
      (1.) If yes, check type of reaction:
      ☐ Rash ☐ Hives ☐ Breathing or other anaphylactic reaction
      (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) Y / N / Don't Know
   h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know
   i. A blood relative who died before age 50? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

____
____
____
____
____

List all medications here:

Medication Name	Dosage	Frequency

NJDOE/APPEF 10/07

Use of this form is required by N.J.A.C. 6A:16-***Programs to Support Student Development***