#85
Revised 7/24/20

STUDENTS IN GRADES 3 AND 6 ARE REQUIRED
TO HAVE A PHYSICAL BY THEIR OWN PHYSICIAN.
PLEASE RETURN THIS FORM TO THE NURSE ALONG
WITH THE ATTACHED PHYSICAL EXAMINATION
FORM #89 WHEN COMPLETED.

EAST AMWELL TOWNSHIP SCHOOL
Ringoes, NJ 08551

PRE-PHYSICAL HEALTH QUESTIONNAIRE

STUDENT'S NAME _____

STUDENT'S GRADE _____ **STUDENT'S DATE OF BIRTH** _____

NAME OF STUDENT'S PHYSICIAN _____

MEDICAL HISTORY

Any history of the following during the past three (3) years that could restrict physical activity:

1.	**Convulsions, concussions or head injuries**	**Yes**_____	**No**_____
	Did your doctor issue clearance for a complete recovery?	**Yes**_____	**No**_____
2.	**Heart disease, murmurs, etc.**	**Yes**_____	**No**_____
3.	**Reaction to bee stings - medication?**	**Yes**_____	**No**_____
4.	**Asthma, medication?**	**Yes**_____	**No**_____
5.	**Hives**	**Yes**_____	**No**_____
6.	**Hernia, kidney or congenital organ disease**	**Yes**_____	**No**_____
7.	**Severe impairment of sensory organs, eyes, ears, etc.**	**Yes**_____	**No**_____
8.	**Fracture, severe strain, sprain or dislocation**	**Yes**_____	**No**_____
	Explain below:		

9.	**Bleeding disorders**	**Yes**_____	**No**_____
10.	**Allergic reaction**	**Yes**_____	**No**_____
	If yes, list reaction & medication:		
11.	**Other orthopedic problems: History of Scoliosis**	**Yes**_____	**No**_____

a. Back **Yes**_____ **No**_____ **b. Hip** **Yes**_____ **No**_____
c. Knee **Yes**_____ **No**_____ **d. Other** **Yes**_____ **No**_____

OVER PLEASE

12. **Medically advised not to participate in any sport** **Yes_____ No_____**
If yes, state reason:

13. **Under a physician's care** **Yes_____ No_____**
If yes, state reason:

14. **Experienced loss of consciousness after an injury** **Yes_____ No_____**

15. **Undergone any surgery** **Yes_____ No_____**

16. **Takes any medication on a regular basis** **Yes_____ No_____**
If yes, state name of medication and reason

Needs emergency medication, explain **Yes_____ No_____**

17. **Experienced frequent chest pains or palpitations** **Yes_____ No_____**

18. **Recent history of fatigue and undue tiredness** **Yes_____ No_____**

19. **History of fainting when exercising** **Yes_____ No_____**

20. **History of a family member having a sudden death** **Yes_____ No_____**

21. **Other illness or injuries not mentioned above**

_____

22. **Does your child wear glasses?** **Yes_____ No_____**
Contact Lenses? **Yes_____ No_____**

23. **Does your child have hearing problems?** **Yes_____ No_____**

PARENT'S SIGNATURE_____ DATE_____

ADDRESS_____

TELEPHONE NUMBER_____