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

This is my signed permission to allow my son/daughter______________________________ to actively participate in school sports at East Amwell Township School. I fully acknowledge that certain physical hazards may be encountered even when the sport activity is properly supervised, protective equipment used and rules strictly enforced and that the physical hazards may be servere in nature.

**NAME OF FAMILY PHYSICIAN**______________________________

**Do you have a Family Hospital Insurance Plan (e.g. Blue Cross)?**______________

**Do you have School Accident Insurance?**______________

## *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 genital 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**_____ | | |
| **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:** | | |

**OVER PLEASE**

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*________________________________________________

*PHONE NUMBER*______________________________

________________________________

*GRADE*__________ *HOMEROOM*______________________________

PHYHQ#85