

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
Ringoos, 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 severe 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 _____