If your child has ever tested positive for COVID-19, your physician must provide us with a clearance to participate note.

New Jersey Department of Education
Health History Update Questionnaire

Name of School: _____

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student's parent or guardian.

Student: _____ Age: _____ Grade: _____

Date of Last Physical Examination: _____ Sport: _____

Since the last pre-participation physical examination, has your son/daughter:

1. Been medically advised not to participate in a sport? Yes ☐ No ☐
   If yes, describe in detail: _____
2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes ☐ No ☐
   If yes, explain in detail: _____
3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes ☐ No ☐
   If yes, describe in detail. _____
4. Fainted or "blacked out?" Yes ☐ No ☐
   If yes, was this during or immediately after exercise? _____
5. Experienced chest pains, shortness of breath or "racing heart?" Yes ☐ No ☐
   If yes, explain _____
6. Has there been a recent history of fatigue and unusual tiredness? Yes ☐ No ☐
7. Been hospitalized or had to go to the emergency room? Yes ☐ No ☐
   If yes, explain in detail _____
8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes ☐ No ☐
9. Started or stopped taking any over-the-counter or prescribed medications? Yes ☐ No ☐
10. Been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐
    If diagnosed with Coronavirus (COVID-19), was your son/daughter symptomatic? Yes ☐ No ☐
    If diagnosed with Coronavirus (COVID-19), was your son/daughter hospitalized? Yes ☐ No ☐
11. Has any member of the student-athlete's household been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

Date: _____ Signature of parent/guardian: _____

Please Return Completed Form to the School Nurse's Office

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New Jersey Department of Education
Health History Update Questionnaire

Athletic Parental Consent Form

Student's Name_____**Grade**_____

Sport _____**School Year**_____

CONSENT

I/we hereby give consent to my son/daughter to participate in the above listed interscholastic sports program during the above listed school year. I/we also give permission for **Emergency Medical Treatment** by the team physician, school nurse, athletic trainer, hospital, and allied medical personnel for conditions arising in athletics. I/We understand that this includes initial and post injury treatment. This includes, but is not limited to: hot/cold modalities, electrical stimulation, ultrasound, muscle strengthening and exercise to increase range of motion and agility. I/We also give permission for preventative care including taping and bracing. I/We also give permission to allow the Athletic Training staff and treating physician to exchange information relating to a specific injury and/or medical condition. This exchange can be in the form of a facsimile, email, or verbal conversation. I/we realize that such activity involves the potential for injury that is inherent in all sports. I/we acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of school rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis or even death. I/we acknowledge that I/we have read and understand this warning. Further, I/ we will not hold Watchung Hills Regional School District, or its representatives responsible in any way for injuries that may occur to my son/daughter because of his/her participation in the sport listed above.

Further, I/we also give permission for medical information regarding my son/daughter to be shared between the districts physician, nurse, athletic trainer, athletic director, and coach.

Please circle ALL that apply:

Asthma: Yes/No

Carries Inhaler : Yes/No

Severe Food/Drug Allergy: Yes/No

Carries Epi-Pen/Benadryl: Yes/No

Name of Food/Drug Allergic to:_____

Diabetes: Yes/No Carries Medication/Snack: Yes/No

Seizure Disorder: Yes/No Rescue medication: Yes/No

Cardiac Issue: Yes/No Please explain:_____

Any other medical concern: _____

Please explain in detail:

_____

_____

_____ _____

Signature Parent/Guardian Date