KITTATINNY REGIONAL HIGH SCHOOL

ATHLETIC DEPARTMENT

HEALTH HISTORY UPDATE

Mr. Brian Bosworth
Principal

Mr. Christopher Carroll
Athletic Director

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

The medical department at the high school will review this information and if there is any question concerning the present condition of the candidate, another physical examination or clearance from your family physician will be required.

COMPLETE THE FORM BELOW AND RETURN TO THE ATHLETIC TRAINER'S OFFICE AS SOON AS POSSIBLE

PRINT NAME OF STUDENT-ATHLETE ____**AGE**_______ **GRADE** _______

I WISH TO BE CONSIDERED A CANDIDATE FOR (NAME OF SPORT) ____

DATE OF MOST RECENT PHYSICAL EXAM (D/M/Y) ____

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, describe 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, describe in detail
____

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____
If yes, name of medication(s) ____

Signature of Parent/Guardian: ______________________________ **Date:** ____________________

Signature of Student-Athlete: _______________________________ **Date:** ____________________

Signature of Athletic Trainer **(after review):** ______________________ **Date:** _____________________

(revised 5/2014 in accordance with NJDOE and NJSIAA)