

# State of New Jersey

## Department of Education

### **HEALTH HISTORY UPDATE QUESTIONNAIRE**

Name of School: **North Hunterdon-Voorhees Regional High School District**

Student: \_\_\_\_\_ School Year: \_\_\_\_\_

Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Sport: \_\_\_\_\_

**Since your son or daughter's last participation on a North Hunterdon-Voorhees Regional High School District sponsored sports team, has the student:**

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 joint? 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. Has there been a recent history of Mono within the last four weeks?  
(Mono/Enlarged Spleen) Yes \_\_\_\_\_ No \_\_\_\_\_

8. Has there been a sudden death in the family? Yes \_\_\_\_\_ No \_\_\_\_\_

9. Has any member of the family under age 50 had a heart attack or "heart trouble" Yes\_\_\_\_No\_\_\_\_

If yes explain: \_\_\_\_\_

\_\_\_\_\_

10. Been hospitalized or had to go to the emergency room? Yes\_\_\_\_No\_\_\_\_

If yes, explain in detail: \_\_\_\_\_

\_\_\_\_\_

11. Have they started/stopped taking any over-the-counter or prescription medications? Yes\_\_\_\_No\_\_\_\_

If yes, name of medication(s): \_\_\_\_\_

\_\_\_\_\_

12. Have they ever had, or do they currently have:

a. A chronic or ongoing illness such as diabetes or asthma? Yes\_\_\_\_No\_\_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

List name of medication or inhaler: \_\_\_\_\_

b. Any allergies to bee stings, foods, pollen or latex? Yes\_\_\_\_No\_\_\_\_

If yes, please check type of reaction Rash \_\_\_\_Hives \_\_\_\_ Anaphylactic Reaction \_\_\_\_

Or other\_\_\_\_\_

c. Do they use an Epi-Pen? Yes\_\_\_\_No\_\_\_\_

If yes, please explain: \_\_\_\_\_

13. Have they had an organ transplant? Yes\_\_\_\_No\_\_\_\_

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

14. Is there any medical information that should be shared with the School Nurse? Yes\_\_\_\_No\_\_\_\_

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Parent/Guardian completing this form (please print): \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_