

**New Jersey Department of Education  
ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM**

**MAYBE ONLY BE COMPLETED IF YOU HAVE COMPLETED THE LONG FORM  
IN THIS YEARS FALL OR WINTER SPORT SEASON**

**Part A: SHORT FORM HEALTH HISTORY QUESTIONNAIRE**

Completed by the parent and student and reviewed by examining provider

**Today's Date:** \_\_\_\_\_ **Date of Last Sports Physical:** \_\_\_\_\_

**Student's Name:** \_\_\_\_\_ **Sex:** M F **Age:** \_\_\_\_ **Grade:** \_\_\_\_ **Home Phone #** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **School:**  Central Middle School **District** Long Hill Township

**Sport (s):** Basketball, Track, Softball, Baseball, Cheerleading, Fencing, WHRHS track day, (Circle one that applies)

**Provider's Name (Medical Home):** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Emergency Contact Information**

Mother/Guardian's Name: _____ Cell # _____ Work# _____	Father's/Guardian's Name: _____ Cell # _____ Work# _____
Additional Emergency Contact: _____	Relationship to Student: _____ Cell # _____ Home# _____

**Health History Information**

**Directions:** Please answer the following questions about the student's medical history by **CHECKING OFF** the correct response.

**Please answer the following questions.**

**Has your child had any:**

▶ <b>hospitalizations, operations, or illness</b> since the date of the last sports physical? ▪ Please list date(s) and reason	No	Yes
▶ <b>injuries</b> , which required medical treatment or an excuse from physical education class since the date of the last sports physical? ▪ Please list date(s) and nature of injury	No	Yes
▶ <b>received care</b> from a medical provider since last sports physical? ▪ Please list date(s) and reason	No	Yes
▶ <b>medications</b> prescribed since the date of the last sports physical ▪ list current medications, dosage and reason for the medications	No	Yes
Medication: _____ Dosage: _____ Rationale: _____		
Medication: _____ Dosage: _____ Rationale: _____		
▶ <b>food, drug or environmental allergies</b>	No	Yes
Allergens: _____		
Medication: Epinephrine Auto Injector Dosage: 0.3 mg	No	Yes
▶ <b>Current Asthma medications</b>	No	Yes
Medication: _____ Dosage: 2 puffs Rationale: allergy or exercise induced Circle one		
▶ <b>diagnosed concussion</b> in last 365 days	No	Yes

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

All items negative/ School Nurse approved:	
School MD approved:	
NOT approved Reason:	
School Physician signature/stamp:	

# Central Middle School

## Emergency Information for Coaches

### I. STUDENT INFORMATION

NAME	Grade ____ Teacher
Address	Home Phone #
Birth date ____/____/____	Gender ____ Male ____ Female

### II. PARENTAL INFORMATION

Father/Guardian's Name	Cell #
Pager #	Employment #
Mother/Guardian's Name	Cell #
Pager #	Employment #

### III. PARENTAL PARTICIPATION CONSENT

<b>Winter</b>	Basketball <input type="checkbox"/>	Cheerleading <input type="checkbox"/>	Fencing <input type="checkbox"/>
<b>Spring</b>	Baseball <input type="checkbox"/>	Softball <input type="checkbox"/>	Track day <input type="checkbox"/> Tennis <input type="checkbox"/>

This sports program is sponsored by the Long Hill Township Public Schools. Realizing that such activity involves the potential for injury, which is inherent in all sports, I/We the parents/guardians of the above-named student acknowledge that even with the best coaching, use of protective equipment and strict observance of rules, injuries are still a possibility. On rare occasion 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. I/we further more release said school district from all liabilities sustained by my child during or resulting from participation in above name sport, and the parent/guardian shall indemnify and hold harmless the school district and its employees or agents from any and all claims arising from participation in school sponsored sport activities.

Parent/ Guardian printed name:	Parent/ Guardian signature:
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### IV. FIRST AID AND EMERGENCY CARE

I, as the legal parent/guardian, of the above-named child/student, hereby consent to and authorize the nearest hospital or health care facility and its physicians in charge of my child's care, to perform emergency treatment and/or diagnostic procedures as deemed necessary or advisable. Additionally, I understand that every attempt will be made to notify me if emergency care is needed for my child. I will not hold the school financially responsible for the emergency care and/or transportation for this child.

**Hospital of choice (emergency care):**

Insurance Co.	Primary insurer's name:	Policy #
Students Physician	Physician #	
Health Insurance Provider:	Phone #	Primary Insurer's name: Policy #
Parent/ Guardian printed name:	Parent/ Guardian signature:	

List one **emergency contact that will be able to pick up your child** in case you cannot be reached in an emergency.

### V. ALTERNATE EMERGENCY CONTACT INFORMATION:

1st. Contact: Name	Home #
Relationship	Employment # Cell/Pager #

### VI. HEALTH HISTORY INFORMATION FOR TEAM COACHES

**N.J. State law restricts the distribution of a student's health information listed on the opposite side of this page without your written consent.** For the health and safety of your child, please consider listing any health related information for released to your child's coaches.

**Allergies:** \_\_\_\_\_

**Medical conditions:** \_\_\_\_\_

**Current medications:** \_\_\_\_\_