

**ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM**  
**Part A: HEALTH HISTORY QUESTIONNAIRE**  
**PARENT AND STUDENT ATHLETE MUST COMPLETE THIS TWO-SIDED FORM**  
**(REQUIRED FOR CONSIDERATION TO PARTICIPATE IN SPORTS)**  
N.J.A.C. 6A:16 *Programs to Support Student Development*

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of last physical: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ 101 Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male  
Female

Grade: \_\_\_\_\_ School: CAPE MAY COUNTY TECHNICAL HIGH SCHOOL District: Cape May

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Please answer the following questions about the student athlete's medical history.**

**Explain "yes" answers at the bottom of the page. Please respond to all questions.**

1. Have you had or do you currently have:

- |   |                    |
|---|--------------------|
| a. A sports physical within the past 365 days?                                      | Y / N / Don't Know |
| b. An injury or illness since your last exam?                                       | Y / N / Don't Know |
| c. A chronic or ongoing illness (such as diabetes or asthma)?                       | Y / N / Don't Know |
| 1. Use an inhaler or other prescription medicine to control asthma?                 | Y / N / Don't Know |
| d. Any prescribed or over-the-counter medications that you take on a regular basis? | Y / N / Don't Know |
| e. Surgery, hospitalization or any emergency room visit(s)?                         | Y / N / Don't Know |
| f. Any allergies to medications?  | Y / N / Don't Know |
| g. Any allergies to bee stings, pollen, latex or foods?                             | Y / N / Don't Know |
| 1. Type of reaction: rash, hives, or skin condition?                                | Y / N / Don't Know |
| 2. Take any medication/Epipen taken for allergy symptoms? (List below)              | Y / N / Don't Know |
| h. Any anemia or blood disorders?   | Y / N / Don't Know |

2. Have you had or do you currently have any of the following *head-related* conditions since your last physical:

- |   |                    |
|---|--------------------|
| a. Concussion requiring a physician's evaluation? | Y / N / Don't Know |
| 1. How often and when? (Answer below.)            |                    |
| b. Memory loss or been knocked out?               | Y / N / Don't Know |
| c. A seizure?                                     | Y / N / Don't Know |
| d. Frequent or severe headaches?                  | Y / N / Don't Know |

3. Have you had or do you currently have any of the following *heart-related* conditions since your last physical:

- |   |                    |
|---|--------------------|
| a. Chest Pain?  | Y / N / Don't Know |
| b. Heart murmur?  | Y / N / Don't Know |
| c. High blood pressure or elevated cholesterol level?   | Y / N / Don't Know |
| d. Restriction from sports for heart problems?          | Y / N / Don't Know |
| e. Any family member or relative:                       |                    |
| 1. Died of a heart problem before age 35?               | Y / N / Don't Know |
| 2. Died of a heart problem before age 50?               | Y / N / Don't Know |
| 3. Died with no known reason?                           | Y / N / Don't Know |
| 4. Died while exercising? During or after? (Circle one) | Y / N / Don't Know |
| 5. Had Marfan's Syndrome?                               | Y / N / Don't Know |

4. Have you had or do you currently have any of the following *eye, ear, nose, mouth or throat conditions* since your last physical:
- a. Vision problems? Y / N / Don't Know
    - 1. Wear contacts, eyeglasses or protective eye wear? (Circle which type) Y / N / Don't Know
  - b. Hearing loss or problems? Y / N / Don't Know
    - 1. Wear hearing aides or implants? Y / N / Don't Know
  - c. Nasal fractures or frequent nose bleeds? Y / N / Don't Know
  - d. Wear braces, retainer or protective mouth gear? Y / N / Don't Know
  - e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? Y / N / Don't Know
5. Have you had or do you currently have any of the following *neuromuscular/orthopedic conditions* since your last physical:
- a. A burner, stinger or pinched nerve? Y / N / Don't Know
  - b. A sprain? Y / N / Don't Know
  - c. A strain? Y / N / Don't Know
  - d. Swelling or pain in muscles, tendons, bones or joints? Y / N / Don't Know
  - e. A dislocated joint(s)? Y / N / Don't Know
  - f. Low back pain? Y / N / Don't Know
  - g. Fracture(s) or stress fracture(s)? Y / N / Don't Know
  - h. Do you wear any protective braces or equipment for any prior injury? Y / N / Don't Know
6. Have you had or do you currently have any of the following *general or exercise-related conditions* since your last physical:
- a. Difficulty breathing? During exercise? (Circle one) Y / N / Don't Know
    - 1. After running 1 mile Y / N / Don't Know
    - 2. Coughing, wheezing or shortness of breath in weather changes? Y / N / Don't Know
    - 3. Been told you have exercise-induced asthma Y / N / Don't Know
      - i. Controlled with medication? (List below) Y / N / Don't Know
      - ii. Experience dizziness, passing out or fainting? Y / N / Don't Know
  - b. Viral infections (e.g. mono, hepatitis)? Y / N / Don't Know
  - c. Become tired more quickly than your friends? Know
  - d. Any of the following skin conditions: Y / N / Don't Know
    - 1. Acne, contact dermatitis, ringworm, warts, herpes? Y / N / Don't Know
    - 2. Sun sensitivity? Y / N / Don't Know
  - e. Weight gain/loss (greater than or less than 10 pounds)? Y / N / Don't Know
    - 1. Do you want to weigh more or less than you do now? Y / N / Don't Know
  - f. Ever had feelings of depression? Y / N / Don't Know
  - g. Heat-related problems (dehydration, dizziness, fatigue, headache)? Y / N / Don't Know
    - 1. Heat exhaustion? (cool, clammy, damp skin) Y / N / Don't Know
    - 2. Heat stroke? (hot, red, dry skin) Y / N / Don't Know
7. **Females only:**  
 Age of onset of menstruation: \_\_\_\_\_ years old      Date of last menstruation: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 Most number of days between your menstruation cycle(s): \_\_\_\_\_

Explain all "Yes" Answers Here (Include relevant dates):

---



---

**I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.202**

**Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ 02**

