

Parsippany-Troy Hills Township Schools
SPORTS Emergency Information Verification Form

(PLEASE PRINT)

Please sign as indicated. Also, please fill in any missing information and make corrections where necessary.

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|---|------------|--|---------------|
| Current School: | | Grade: | SPORT: |
| Student's Name: | | DOB: | Sex: |
| Legal Residence: | | Mailing Address if different than residence: | |
| Please include company name for work numbers, so that if your company changes phone numbers we will still be able to locate you. Emergency numbers will only be used in the event that we cannot reach you at the other numbers listed. | | | |
| Guardian 1: | | Primary #: | E-Mail: |
| Home: | Home Cell: | Work: | Work Cell: |
| Guardian 2: | | Primary #: | E-Mail: |
| Home: | Home Cell: | Work: | Work Cell: |
| Emergency 1: | | Primary # | E-Mail: |
| Home: | Home Cell: | Work: | Work Cell: |
| Emergency 2: | | Primary #: | E-Mail: |
| Home: | Home Cell: | Work: | |

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|---|--|
| <p>Health Information: Medical Alerts/Allergies</p> <p>Receives Daily Medication (y/n)</p> <p>Wears glasses and/or contacts (y/n)</p> | <p>Date of Last Physical: <u>FOR OFFICE USE ONLY</u></p> <p> </p> <p>Nurse's Office Stamp</p> <p> </p> <p>Date Impact Tested</p> |
|---|--|

Health Care Provider Information (for emergency treatment when we are unable to contact you)

| Contact Type | Contact Name | Contact Number |
|--------------|--------------|----------------|
| Hospital | | |
| Doctor | | |

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| <p>Does your child have health insurance coverage? Yes No</p> <p>If yes, what is the name of the Insurance Company?</p> | <p>Please sign here to indicate that we have your permission to call the physicians listed or to have your child taken to the hospital when you are not available or in an emergency.</p> <p style="text-align: center; margin-top: 20px;">_____</p> <p style="text-align: center;">Parent/Guardian Signature Date</p> |
|---|---|

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 _____
If yes, name of medication(s) _____

Date: _____ Signature of parent/guardian _____