

**New Jersey Department of Education
Health History Update Questionnaire**

Name of School: Shore Regional High School

Sport: _____

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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: _____

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 (explain) 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, please list medications.

10. If you answer yes to these questions; please complete the back of this form.
 Been diagnosed with Coronavirus (COVID-19)? Yes No
 If diagnosed with Coronavirus (COVID-19), was your son/daughter symptomatic? Yes No
 If diagnosed with Coronavirus (COVID-19), was your son/daughter hospitalized? Yes No
11. Has any member of the student-athlete's household been diagnosed with Coronavirus (COVID-19)? Yes No

Date: _____ **Signature of parent/guardian:** _____

Please Return Completed Form to the SchoolNurse's Office

**COVID-19
Return To Play Screening Form**

Student's Name: _____

Date of Positive Covid Test: _____ Symptom Onset: _____

Criteria for Return to Sports: Patient satisfies the terms below and answers to Cardiac Screening questions are all "NO".

Y N Asymptomatic or Mild Symptoms: Less than 4 days of fever > 100.4, fatigue, chills, or myalgias.

Y N 5 days have passed since the positive test and onset of symptoms

Y N Minimum of 24 hours symptom-free off fever reducing medication

Cardiac screening-Is the student experiencing ANY of the following?

Was the athlete hospitalized for COVID-19 infection? Y N

Chest pain/tightness or shortness of breath with exertion Y N

Unexplained syncope/near syncope Y N

Unexplained/excessive fatigue with exertion Y N

Heart palpitations(new) Y N

Abnormal cardiac exam or vital signs Y N

_____ If student **HAS** satisfied the above criteria; then they are **CLEARED** to start Return to Play progression. **Parent and student sign form below.**

_____ If student **HAS NOT** satisfied the above criteria; then they are **NOT CLEARED** to start Return to Play progression and will need medical clearance. **Physician signature required.**

Student's Signature

Parent Signature

Date

_____ is medically cleared to participate in sports.
Student's Name

Physician's Signature

Date