

**New Jersey Department of Education  
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

10. 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 School Nurse's Office**

Check one

**PATERSON PUBLIC SCHOOLS**

\_\_\_\_\_ **JFK EDUCATIONAL COMPLEX, 61-127 PREAKNESS AVENUE, PATERSON, NJ 07522**

\_\_\_\_\_ **EASTSIDE HIGH SCHOOL, 150 PARK AVENUE, PATERSON, NJ 07501**

**PERMISSION/ACKNOWLEDGEMENT FORM:**

**STUDENT NAME:** \_\_\_\_\_ **GRADE:** \_\_\_\_\_ **DOB** \_\_\_\_\_ **AGE** \_\_\_\_\_

I hereby give permission for my son/daughter to participate in, travel with and be responsible for the return of all equipment in the following sports:

**SPORT(S)** \_\_\_\_\_

I release the school from all liability resulting from participation in these programs.

REALIZING THAT SUCH ACTIVITY INVOLVES THE POTENTIAL FOR INJURY WHICH IS INHERENT IN ALL SPORTS. I/WE ACKNOWLEDGE THAT EVENTHE BEST COACHING, USE OF THE MOST ADVANCED PROTECTIVE EQUIPMENT AND STRICT OBSERVANCE OF RULES, INJURIES ARE STILL A POSSIBILITY. ON RARE OCCASIONS THESE INJURIES CAN BE SO SEVER AS TO RESULT IN TOTAL DISABILITY, PARALYSIS OR DEATH. I/WE ACKNOWLEDGE THAT I/WE HAVE READ AND UNDERSTAND THIS WARNING.

I will be responsible for any athletic equipment loaned to my child by the school and will reimburse the school for any loss.

I also understand that only those medical expenses not covered by my own personal or group insurance are eligible for coverage by Paterson Public School District insurance policy up to the specified limits.

I understand that in the case of injury to my child, all medical bills must be submitted to my personal or group insurance first.

**PLEASE NOTE:** The Board of Education has purchased insurance coverage that protects all participants in interscholastic athletics against accidental injury. The following will explain the coverage. **IN THE EVENT OF PHYSICIAN, HOSPITAL, AND/OR SURGICAL EXPENSES, THIS POLICY BECOMES EXCESS OVER ANY OTHER INSURANCE YOU MAY HAVE. PARENTS MUST USE THEIR OWN INSURANCE FIRST. PATERSON BOARD OF EDUCATION’S INSURANCE WILL THEN PAY THOSE BILLS NOT COVERED BY YOUR OWN INSURANCE, UP TO THE LIMITS OF THE POLICY. PARENTS MUST SUBMIT ALL MEDICAL FORMS TO THE INSURANCE COMPANY.**

Although this coverage is very broad, there **are restrictions, limitations and exclusions in this policy.** In many situations **medical bills may not be covered in full.** Parents should understand that medical expenses are their own responsibility, not the Board of Education.

Please report any injuries immediately to the **ATHLETIC TRAINER OR YOUR CHILD’S COACH.** The school upon your request will provide claim forms and it will be the parent’s responsibility to obtain all medical bills and submit them to the insurance company. Please be sure to obtain the claim form from the school by the time you receive your medical bills. **BMI Benefits, LLC.,** telephone **800-445-3126,** can best answer questions regarding the policy coverage or about specific claims. **Claim form must be completed within 90 days of injury.**

**I understand that I am liable for any medical bills remaining after the above procedures have been carried out.**

**I acknowledge receipt of the explanation of medical benefits, which describes the coverage, benefits and exclusions of the insurance program in force for the athletes and other participants in the athletic program in Paterson.**

**DATE:** \_\_\_\_\_

**PARENT/GUARDIAN NAME: (PRINT)** \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_

**PERSONAL/GROUP MEDICAL INSURANCE** \_\_\_\_\_

**POLICY#** \_\_\_\_\_ **GROUP #** \_\_\_\_\_

**PHONE (HOME)** \_\_\_\_\_ **WORK** \_\_\_\_\_ **CELL** \_\_\_\_\_

**In case of emergency contact: NAME** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**Known Allergies to Medications** \_\_\_\_\_