LAWRENCE TOWNSHIP PUBLIC SCHOOLS

Medical History Update Form

COMPLETE AND RETURN TO THE NURSE'S OFFICE ONLY IF THE STUDENT HAS A CURRENT PRE-PARTICIPATION PHYSICAL ON FILE WITH THE NURSE.

___________________________ ________________________________ ___________ __________________________

FIRST NAME LAST NAME GRADE SPORT(S)

GENDER: M OR F DATE OF BIRTH: _________________________

ALLERGIES: YES OR NO **DO YOU CARRY AN EPI-PEN? YES OR NO**

FOOD: ____________________________________ **SEASONAL:** ____

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: By whom: ____
   If yes, describe in detail: ____
   ____
2. Sustained a concussion, been unconscious or lost memory from 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. Do you have Asthma? YES OR NO Do you carry an inhaler: YES NO
6. Is there a recent history of fatigue and/or unusual tiredness? YES NO
   If yes, describe in detail: ____
7. Been hospitalized or had surgery since your last athletic physical? YES NO
   If yes, describe 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?" Relationship:_____________________________________ YES NO
9. Do you have any restrictions due to injury or illness? YES NO
   If yes, describe in detail: ____
10. Started or stopped taken any prescribed medication or over the counter medication? YES NO
    If yes, name of medication: ____

*****Current Medications taken:***

NAME OF MEDICATION	DOSAGE	FREQUENCY

I, as a student of the Lawrence Township Public Schools, request permission to participate in the above named interscholastic sport during the 20___/20___ school year.

____ _____________________________________ ___________________

Student Signature Print Student Name Date

I certify that the information provided is accurate to the best of my knowledge.

____ _____________________________________ ___________________

Parent/Guardian Signature Print Parent/Guardian Name Date

*****INCOMPLETE FORMS WILL BE RETURNED. FORMS SUBMITTED AFTER THE ANNOUNCED DEADLINE WILL NOT BE ACCEPTED.*****

FOR OFFICIAL USE ONLY:

Physician's note of clearance on file: Y or N Nurse's Signature: _______________________________________ Date: ___________

Date of Students last physical exam: _____________________

Student-athlete is medically eligible: Y or N Athletic Trainer's Signature: ______________________________ Date: ___________