

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.

Current School:		Grade:	<b>SPORT:</b>
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.			
<b>Guardian 1:</b>		Primary #:	E-Mail:
Home:	Home Cell:	Work:	Work Cell:
<b>Guardian 2:</b>		Primary #:	E-Mail:
Home:	Home Cell:	Work:	Work Cell:
<b>Emergency 1:</b>		Primary #	E-Mail:
Home:	Home Cell:	Work:	Work Cell:
<b>Emergency 2:</b>		Primary #:	E-Mail:
Home:	Home Cell:	Work:	

<b>Health Information:</b> Medical Alerts/Allergies  Receives Daily Medication (y/n)  Wears glasses and/or contacts (y/n)	<b>Date of Last Physical:</b> <u>FOR OFFICE USE ONLY</u>  Nurse's Office Stamp  Date Impact Tested
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**Health Care Provider Information** (for emergency treatment when we are unable to contact you)

Contact Type	Contact Name	Contact Number
Hospital		
Doctor		

Does your child have health insurance coverage? Yes      No  If yes, what is the name of the Insurance Company?	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.  <hr style="width: 80%; margin-left: auto; margin-right: auto;"/> <div style="display: flex; justify-content: space-between; width: 80%; margin-left: auto; margin-right: auto;"> <span><b>Parent/Guardian Signature</b></span> <span><b>Date</b></span> </div>
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**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 \_\_\_\_\_