

RECERTIFICATION FOR SPORTS PARTICIPATION

Haddon Township High School

Use only if athlete has been cleared to participate in a previous sport within the past 365 days. Physicals must be on file in nurse's office and on state approved form.

Date of last physical: _____ (If > 365 days will need new physical) Date of Impact Test: _____

Date _____ Sport _____ Age _____ Grade/HR _____

Name _____

Parent/Guardian _____ Emergency Number _____

Home Address _____ Home Phone _____

List medications currently taking including over the counter meds such as allergy medications, vitamins, Tylenol, Herbal preparations: _____

Since your last physical, have you had the following: **If yes please explain in line provided and continue on back if needed.**

Any injury related to sports? Yes/No _____

Any injury no related to sports? Yes/No _____

Any operations? Yes/No _____

Any illness requiring you to be seen by a doctor or hospitalized? Yes/No _____

Any head injury or concussion? Yes/No _____

Any dizzy spells, black outs or unconsciousness? Yes/No _____

Any shortness of breath? Any history of Asthma or reactive airway disease? Yes/No _____

Any chest pains or heart palpitations? Yes/No _____

Any new health problems develop over the past year? Yes/No _____

Did any family member get diagnosed with heart disease, diabetes, or die suddenly in the past year? Yes/No _____

Do you have any allergies that cause hives or shortness of breath? Yes/No _____

Are you allergic to bees or other insects? Yes/No. Have you ever been instructed to carry an Epi Pen? Yes/No _____

Do you have any allergies to food or medication? Yes/No. If so, please list and state if the allergy is life threatening _____

Do you have any other symptom or illness not otherwise mentioned? Yes/No _____

Signature of parent/guardian _____ Date: _____

Signature of athlete _____ Date: _____

****For School Office Use Only: Date Received _____ School Nurse or Physician Review: _____**

