



**SCHALICK H. S. ATHLETIC DEPARTMENT
MICHAEL CLARKE, DIRECTOR OF ATHLETICS
(856) 358-2054 EXT. 4119**

Dear Parents:

Your son/daughter has expressed a desire to participate in the Interscholastic Athletic Program at school. We expect each athlete to be a credit to himself/herself, his/her family and the school.

A Student Pre-Participation Physical Form will be given to athletes requiring a new physical to be completed by their physician. Athletes with a current physical will be given a Health History Update to be filled out and signed by parent/guardian.

1. The entirety of the physical packet is to be completed by your family physician, Physician Assistant or Nurse Practitioner and submitted to the school nurse at least **2 weeks prior** to the first official day of practice. **If you do not have a family physician or nurse practitioner the student must contact the school nurse immediately to make arrangements for a medical examination.** The physical and health history forms are required by New Jersey School Law and must be completed every 365 days.
2. If the child's physical is still current a Health History Update Questionnaire's must be completed within 90 days of a new sports season. The update informs us of any changes to your child's health since their last physical. **The parent must sign and date bottom of the page.**

Please carefully read and sign the Parent Approval Form as well as the athletic registration forms online at <https://schalick-ar.rschoolday.com>. **Before a student may participate in athletics, all forms must be completed online and the physical exam form submitted for review and approval by the school doctor.**

Timelines for submission of forms are as follows:

Fall Sports, last day of school in June; Winter Sports, November 1; Spring Sports, February 28th.

Once again all registration forms must be completed online immediately; Physical Exam forms must be submitted and reviewed by the school doctor prior to participation in athletics. Any form not filled out in its entirety will be returned to the athlete for completion. This procedure has been adopted for the welfare of our students. With your cooperation, it can be carried out with minimum inconvenience and maximum effectiveness.

If I can be of any service to you, please feel free to contact me at the Athletic Office.

Sincerely,
Michael Clarke
Director of Athletics

"IT'S A MATTER OF PRIDE"

Avoid Delays in Clearing Sport Physicals

To avoid delays in clearing sports physicals, be sure to turn in your paperwork on time.

MAKE SURE:

- All sections of the physical examination form are completed in ink.
- On page 1 (History form), please provide explanations to all yes answers on the history form, including age or year of illnesses, injuries and/or surgeries on lines provided under question 54.
- Student and parent must both sign bottom of page 1 and date.
- Page 2 (Athletes with Special Needs: Supplementary History Form) is for students who have physical disabilities due to birth injuries, genetic malformation, accidental injuries, trauma or other causes.
- All sections of page 3 need to be completed including vision (doctor cannot document sees eye doctor or declined in office), blood pressure, pulse and date of physical exam.
- The clearance box is checked on both pages 3 and 4.
- Include clearance notes from doctor with date for any injuries and/or illnesses checked off on the history form.
- The doctor signed the cardiac assessment module on the last page and the office stamp is on page 4.
- Asthma action plans and anaphylaxis/allergy action plans are only valid for school year they are submitted. All students with asthma or anaphylaxis allergies must submitting a new plan with their fall sports physical. If students have outgrown their asthma or allergies, a letter from their MD/PA/APN must be provided with their sports physical.
- Lastly, check over the forms before submitting them to make sure they are complete.

For physical questions, contact Nurse Bokma: JBokma@pittsgrove.net

For clearance questions, contact Ms. Benson: LBenson@pittsgrove.net

All other athletic questions, contact Mr. Clarke: MClarke@pittsgrove.net

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 _____

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 _____

PLEASE RETURN COMPLETED FROM TO THE SCHOOL NURSES'S OFFICE

Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)



(Please Print)

Name		Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)		Emergency Contact
Phone	Phone		Phone

HEALTHY (Green Zone) IIII ➔



You have all of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230	2 puffs twice a day
<input type="checkbox"/> Aerospir™	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Alvesco® <input type="checkbox"/> 80, <input type="checkbox"/> 160	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Dulera® <input type="checkbox"/> 100, <input type="checkbox"/> 200	2 puffs twice a day
<input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220	2 puffs twice a day
<input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160	<input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day
<input type="checkbox"/> Advair Diskus® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500	1 inhalation twice a day
<input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Flovent® Diskus® <input type="checkbox"/> 50 <input type="checkbox"/> 100 <input type="checkbox"/> 250	1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180	<input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Pulmicort Respules® (Budesonide) <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0	1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Singulair® (Montelukast) <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg	1 tablet daily
<input type="checkbox"/> Other	
<input type="checkbox"/> None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take _____ puff(s) _____ minutes before exercise.

Triggers

Check all items that trigger patient's asthma:

- Colds/flu
- Exercise
- Allergens
 - Dust Mites, dust, stuffed animals, carpet
 - Pollen - trees, grass, weeds
 - Mold
 - Pets - animal dander
 - Pests - rodents, cockroaches
- Odors (Irritants)
 - Cigarette smoke & second hand smoke
 - Perfumes, cleaning products, scented products
 - Smoke from burning wood, inside or outside
- Weather
 - Sudden temperature change
 - Extreme weather - hot and cold
 - Ozone alert days
- Foods:
 - _____
 - _____
 - _____

CAUTION (Yellow Zone) IIII ➔



You have any of these:

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: _____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from _____ to _____

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
<input type="checkbox"/> Xopenex®	2 puffs every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Duoneb®	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Combivent Respimat®	1 inhalation 4 times a day
<input type="checkbox"/> Increase the dose of, or add:	
<input type="checkbox"/> Other	

• If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.

EMERGENCY (Red Zone) IIII ➔



Your asthma is getting worse fast:

- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other: _____

And/or Peak flow below _____

Take these medicines NOW and CALL 911. Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
<input type="checkbox"/> Xopenex®	4 puffs every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	1 unit nebulized every 20 minutes
<input type="checkbox"/> Duoneb®	1 unit nebulized every 20 minutes
<input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	1 unit nebulized every 20 minutes
<input type="checkbox"/> Combivent Respimat®	1 inhalation 4 times a day
<input type="checkbox"/> Other	

- Other: _____
 - _____
 - _____
 - _____
- This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

Disclaimer: This asthma action plan is intended to be used as a guide only. It does not constitute a medical prescription. The patient's physician should be consulted for specific instructions regarding the use of this plan. The patient's physician should be consulted for specific instructions regarding the use of this plan. The patient's physician should be consulted for specific instructions regarding the use of this plan.

Permission to Self-administer Medication:

- This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.
- This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE _____ DATE _____

Physician's Orders

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP _____

REVISED MAY 2017

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Make a copy for parent and for physician file, send original to school nurse or child care provider.

Asthma Treatment Plan – Student Parent Instructions



The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. Parents/Guardians: Before taking this form to your Health Care Provider, complete the top left section with:

- Child's name
- Child's date of birth
- Child's doctor's name & phone number
- An Emergency Contact person's name & phone number
- Parent/Guardian's name & phone number

2. Your Health Care Provider will complete the following areas:

- The effective date of this plan
- The medicine information for the Healthy, Caution and Emergency sections
- Your Health Care Provider will check the box next to the medication and check how much and how often to take it
- Your Health Care Provider may check **"OTHER"** and:
 - ❖ Write in asthma medications not listed on the form
 - ❖ Write in additional medications that will control your asthma
 - ❖ Write in generic medications in place of the name brand on the form
- Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:

- Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Child's asthma triggers on the right side of the form
- Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. Parents/Guardians: After completing the form with your Health Care Provider:

- Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
- Keep a copy easily available at home to help manage your child's asthma
- Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature

Phone

Date

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

- I do request that my child be **ALLOWED** to carry the following medication _____ for self-administration in school pursuant to N.J.A.C.:6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.
- I **DO NOT** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature

Phone

Date



**PLACE
PICTURE
HERE**

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: **Yes (higher risk for a severe reaction)** **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

If checked, give epinephrine immediately if the allergen was **LIKELY** eaten, for **ANY** symptoms.

If checked, give epinephrine immediately if the allergen was **DEFINITELY** eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:
SEVERE SYMPTOMS



LUNG

Shortness of breath, wheezing, repetitive cough



HEART

Pale or bluish skin, faintness, weak pulse, dizziness



THROAT

Tight or hoarse throat, trouble breathing or swallowing



MOUTH

Significant swelling of the tongue or lips



SKIN

Many hives over body, widespread redness



GUT

Repetitive vomiting, severe diarrhea



OTHER

Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.



- 1. INJECT EPINEPHRINE IMMEDIATELY.**
- 2. Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS



NOSE

Itchy or runny nose, sneezing



MOUTH

Itchy mouth



SKIN

A few hives, mild itch



GUT

Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

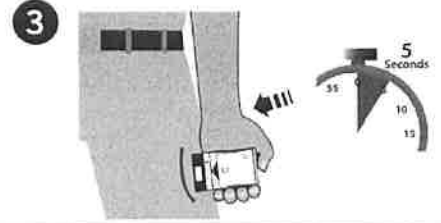
Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____



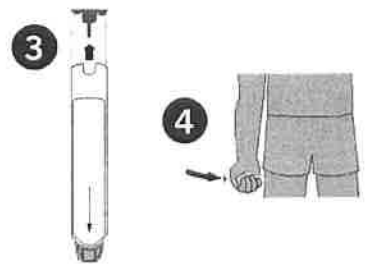
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly, and hold in place for 5 seconds.
5. Call 911 and get emergency medical help right away.



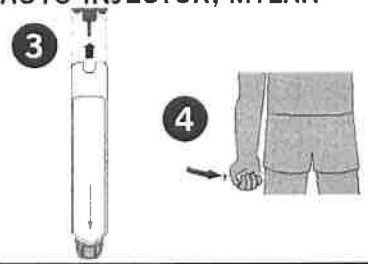
HOW TO USE EPIPEN® AND EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



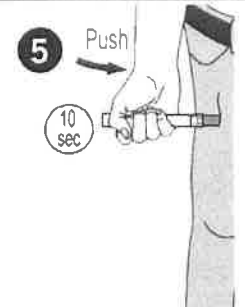
HOW TO USE EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN

1. Remove the epinephrine auto-injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, IMPAX LABORATORIES

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-injector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD _____
 DOCTOR _____ PHONE: _____
 PARENT/GUARDIAN _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____
 PHONE: _____
 NAME/RELATIONSHIP: _____
 PHONE: _____

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			40. Have you ever become ill while exercising in the heat?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			52. Have you ever had a menstrual period?		
			53. How old were you when you had your first menstrual period?		
			54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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HE0503

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

9-2681/0410

PREPARTICIPATION PHYSICAL EVALUATION THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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New Jersey Department of Education 2014; Pursuant to P.L. 2013, c. 71

NOTE: The preparticipation physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practitioner nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
^bConsider GU exam if in private setting. Having third party present is recommended.
^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____
- Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex M F Age _____ Date of birth _____

- Cleared for all sports without restriction
 Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____

Recommendations _____

EMERGENCY INFORMATION

Allergies _____

Other information _____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____