

Northern Burlington County Regional School District
160 Mansfield Road East
Columbus, New Jersey 08022

Athletic Participation Packet

Dear Parent/Guardian:

In order to participate in interscholastic athletics each student athlete is required to complete the following for each sport:

- Please check off and initial on the **Athletic Participation Packet Required Forms Parent/Guardian Checklist** to ensure the Athletic Participation Packet is complete. Turn this form in with the Athletic Participation Packet.
- ❖ Complete and have the parent/guardian sign the **Athletic Emergency Information form and Permission to Treat form (page 1)**.
- ❖ Complete and have the parent/guardian and student sign the **Permission to Engage in Athletics and the Eligibility Standards, Medical Changes and Equipment Responsibility Form (page 2)**.
- ❖ Complete and have the parent/guardian and student sign the **Asthma Awareness Questionnaire (All Athletes)** **If student athlete has been diagnosed with asthma, the attached Asthma Action Plan form is required to be completed by treating physician for the student/athlete to participate (pages 3 and 4)**.
- ❖ Complete and have the parent/guardian and student sign the **Part A Health History Questionnaire (pages 5-7)**. **This Health History Questionnaire must be reviewed by the examining physician as part of the physical evaluation.** One for each season must be completed **60** days prior to the start of a season.
- ❖ Home physician must administer annually **Part B Physical Evaluation Form (page 8-11)** for student participation in sports. The physician must stamp and sign this form. This document is kept on file in the School Nurse's office. Please encourage your family physician to complete the most recent immunization dates. Each student must have a physical within one calendar year of the first day of practice for that particular sport. Considering the difficulty of making an appointment with a physician, this should be done well in advance of the beginning of each sport season. All Athletic Participation Packets will be reviewed by the school doctor and will notify parent/guardian regarding their child's ability to participate in sports.
- ❖ Please read and have the parent/guardian and student athlete sign the **NJSIAA Steroid Testing Policy Consent to Random Testing form (page 12)**. **HIGH SCHOOL ONLY**
- ❖ Please read the **NJSIAA Banned-Drug Classes (page 13)** sheet. **HIGH SCHOOL ONLY**

- ❖ **All High School forms must be turned into the Athletic Office within the specified dates listed below. All Middle School forms must be turned into the Middle School Main Office within the specified dates listed below. Due dates are:**

<u>High School</u>	<u>Middle School</u>
○ Fall - June 30th - August 2nd	Fall - July 30th - August 30th
○ Winter - September 30th - November 2nd	Winter - September 30th - November 2nd
○ Spring - January 6th - February 2nd	Spring - January 6th - February 2nd

Thank you for your attention and cooperation in accurately completing these forms. This will hopefully provide our personnel with the most up to date information for quality care of our athletes.

Sincerely,

Christine M. Haines
Director of Athletics
609-298-3900, ext. 2093

NORTHERN BURLINGTON COUNTY REGIONAL SCHOOL DISTRICT

160 Mansfield Road East
Columbus, NJ 08022
609-298-3900

**Athletic Participation Packet Required Forms
Parent/Guardian Checklist**

Parent/Guardian check

School check

- Athletic Emergency Information Form (new form needed for each sport season)
- Permission To Engage in Athletics (new form needed for each sport season)
- Asthma Awareness Questionnaire (date within 60 days prior to each sport)
- Asthma Treatment Plan (once a year if applicable)
- Part A: PARENT Health History Questionnaire (date within 60 days prior to each sport) (review with physician at yearly physical)
- Part B: Physical Evaluation Form completed by physician, must provide Physician's signature, stamp and date of exam (completed every 365 days, does not need to be reviewed for each sports season)

A NEW PACKET IS FILLED OUT FOR EACH SPORT

*****ONLY PACKETS COMPLETED IN THEIR ENTIRETY WILL BE ACCEPTED FOR PROCESSING FOR PARTICIPATION. ATHLETES' PACKETS THAT ARE RECEIVED AFTER THE DUE DATES MAY NOT BE ABLE TO START PRACTICE ON THE FIRST DAY AND WILL WAIT UNTIL MEDICAL AND ACADEMIC CLEARANCE IS REVIEWED BEFORE THEY CAN PRACTICE. *****

Parent/Guardian initials _____

School Official initials _____

High School Due Dates

FALL - June 30th - August 2nd
WINTER - September 30th - November 2nd
SPRING - January 10th - February 2nd

Middle School Due Dates

FALL - July 30th- August 30th
WINTER - September 30th- November 2nd
SPRING - January 10th - February 2nd

Northern Burlington County Regional School District

ATHLETIC EMERGENCY INFORMATION

Please Print

GRADE _____

Pupil _____ Sport _____
(Last) (First)

Home Address _____ Home Phone _____

FatherEmployment _____ MotherEmployment _____

Father/Guardian work # _____ Mother/Guardian work# _____

Cell Phone # _____ Cell Phone # _____

Family Physician _____ Family Dentist _____

Phone # _____ Phone # _____

Person designated to care for child when parent is not available:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Hospital Preference _____

Medications begin taken: _____

Allergies: _____

Significant

MedicalHistory: _____

Northern Burlington County Regional School District

PERMISSION TO TREAT

I hereby give my permission, that in case of emergency, _____
may be taken to the hospital for treatment. The School Physician and/or the Certified Athletic Trainer and/or the School Nurse may also treat the student athlete when treatment is necessary.

Signature of Parent/Guardian

Date

**Northern Burlington County Regional School District
PERMISSION TO ENGAGE IN ATHLETICS**

(THIS CARD MUST BE FILED WITH THE DIRECTOR OF ATHLETICS BEFORE AN ATHLETE MAY PARTICIPATE)

Grade

Date

Date of Birth

Place of Birth

____ Male ____ Female (Please check one)

TO THE PRINCIPAL:

I request to be enrolled as a candidate for the school team in _____ Player ____ Mgr. ____
(Please list sport) (Please check one)

I acknowledge that physical hazards may be encountered in the conduct of the sport.

Signature of Student

Print Name

TO THE PRINCIPAL:

I hereby grant permission for my child _____ to participate in _____.
(Print child's name) (Sport)

N.J.A.C. 6:29-6.4 Realizing that such activity involves the potential for injury which is inherent in all sports, I/we acknowledge that even with the 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 severe as to result in total disability, paralysis or even death. I/we acknowledge that I/we have read and understand this warning. I grant permission for the school physician and/or certified athletic trainer and/or school nurse to treat my child as necessary.

I hereby give my permission that in case of an emergency, _____ may be taken to the hospital for treatment.

Signature of Parent/Guardian or Student if age 18 or older

**Northern Burlington County Regional School District
ELIGIBILITY STANDARDS/MEDICAL CHANGES/EQUIPMENT**

To the Parent/Student:

Northern Burlington /NJSIAA eligibility standards require that a student successfully complete 27.5 credits during the previous academic year to be eligible to participate in fall/winter sports or activities. At the end of the first semester a student must have passed 13.75 credits to participate in a spring sport. Once a student begins a sport season (winter), he/she will be permitted to complete it.

Credits earned in summer school can only be applied to the preceding year.

I also understand that my son/daughter is responsible for all equipment/uniforms/medical supplies issued. Failure to return equipment/uniforms/medical supplies will require reimbursement to the school.

“Any significant medical changes which occur, or that are discovered during the course of the season need to be reported immediately to the school nurse (e.g. asthma, injury, illness, pregnancy).

Signature of Student

Date

Signature of Parent

Date

For Northern Burlington Nurse's Office ONLY:

Date of Physical

Nurse's Signature and Date

ASTHMA AWARENESS QUESTIONNAIRE

Asthma is a chronic, inflammatory lung disease involving recurrent breathing problems. It is a condition that has generally not been treated as seriously as other chronic diseases. However, according to the National Institute of Allergy and Infectious Diseases asthma is the most common serious disease among children in the United States. It is blamed for more than 5,000 deaths per year and 10 million school absences.

The incidence of diagnosed asthma has increased significantly over the last two decades. Even though extensive research has taken place during this time, the disease is still misunderstood. Many times it is not treated as aggressively as it could be. Worst yet it is not treated at all.

Because of the serious implications of asthma, Northern Burlington County Regional School District is taking a proactive stance by gathering more information. With this information we can better identify athletes at risk, help asthmatic athletes achieve maximum performance under the safest conditions and possibly help prevent a tragedy.

Thank you for your cooperation. If you have any questions or concerns, please contact:
In the High School: Diane Applegate RN, Eileen Mancini RN, Laura Tewes RN or Erin Cearfoss ATC.
In the Middle School: Dana Beaver, RN

All students should complete this document.

Name _____
Age: _____ Height: _____ Weight: _____

- | | Yes | No |
|--|-------|-------|
| 1. Do you ever have wheezing? | _____ | _____ |
| 2. Does running ever cause chest tightness or cough or wheezing or prolonged shortness of breath? | _____ | _____ |
| 3. Have you ever had chest tightness, cough, wheezing, asthma or other? Chest (lung) problems that make it difficult for you to perform in sports? | _____ | _____ |
| 4. Have you ever missed school, work or practice because of lung disease? (pneumonia) chest tightness or cough or wheezing or prolonged shortness of breath? | _____ | _____ |
| 5. Do you have trouble breathing or do you cough (locker room cough) during or after activity? | _____ | _____ |

_____ My son/daughter has **never** been diagnosed with asthma, exercise induced asthma, broncho spasm nor have they ever had any breathing difficulty.

_____ My son/daughter has been diagnosed with asthma, exercise induced asthma or some form of respiratory problem. **Attached form is required to be filled out by treating physician.**

My son/daughter is: _____ taking medication to control their problem.
_____ not currently taking medication and rarely experiences any breathing difficulty.

Student athlete signature Date Parent/Guardian signature Date

If student has been diagnosed with asthma, the attached Asthma Action Plan form is required to be completed by treating physician.

Asthma Treatment Plan

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

The Pediatric/Adult
Asthma Coalition
of New Jersey
"Your Pathway to Asthma Control"
Original PACNJ approved Plan available at
www.pacnj.org

Sponsored by
**AMERICAN
LUNG
ASSOCIATION**
of New Jersey



(Please Print)

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

HEALTHY



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 medicine(s). All metered dose inhalers (MDI) to be used with spacers.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Advair® 100, 250, 500	.....1 inhalation twice a day
<input type="checkbox"/> Advair® HFA 45, 115, 230	.....2 puffs MDI twice a day
<input type="checkbox"/> Asmanex® Twisthaler® 110, 220	..1 - 2 inhalations a day
<input type="checkbox"/> Flovent® 44, 110, 220	.....2 inhalations twice a day
<input type="checkbox"/> Flovent® Diskus® 50 mcg	.....1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® 90, 180	..1 - 2 inhalations once or twice a day
<input type="checkbox"/> Pulmicort Respules® 0.25, 0.5, 1.0	..1 unit nebulized once or twice a day
<input type="checkbox"/> Qvar® 40, 80	.....2 inhalations twice a day
<input type="checkbox"/> Singulair 4, 5, 10 mg	.....1 tablet daily
<input type="checkbox"/> Symbicort® 80, 160	.....2 puffs MDI twice a day
<input type="checkbox"/> Other	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take this medicine _____ minutes before exercise.

Triggers

Check all items that trigger patient's asthma:

- Chalk dust
- Cigarette Smoke & second hand smoke
- Colds/Flu
- Dust mites, dust, stuffed animals, carpet
- Exercise
- Mold
- Ozone alert days
- Pests - rodents & cockroaches
- Pets - animal dander
- Plants, flowers, cut grass, pollen
- Strong odors, perfumes, cleaning products, scented products
- Sudden temperature change
- Wood Smoke
- Foods:
- _____
- _____
- _____
- Other:
- _____
- _____
- _____

CAUTION



You have any of these:

- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: _____

And/or Peak flow from _____ to _____

Continue daily medicine(s) and add fast-acting medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Accuneb® 0.63, 1.25 mg	.....1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol 1.25, 2.5 mg	.....1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil®	..2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex®	..2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Xopenex® 0.31, 0.63, 1.25 mg	..1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Increase the dose of, or add:	

➔ If fast-acting medicine is needed more than 2 times a week, except before exercise, then call your doctor.

EMERGENCY



Your asthma is getting worse fast:

- Fast-acting medicine did not help within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue

And/or Peak flow below _____

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

<input type="checkbox"/> Accuneb® 0.63, 1.25 mg	.....1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol 1.25, 2.5 mg	.....1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil®	..2 puffs MDI every 20 minutes
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex®	..2 puffs MDI every 20 minutes
<input type="checkbox"/> Xopenex® 0.31, 0.63, 1.25 mg	..1 unit nebulized every 20 minutes
<input type="checkbox"/> Other	

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

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey, and this publication are accepted by a grant from the New Jersey Department of Health and Senior Services (NJDEH), 40 funds provided by the U.S. Center for Disease Control and Prevention (CDC) under Cooperative Agreement 5U29CE000002. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NJDEH or the CDC.

Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement No. 80900441-4 and 80675070-1 to the American Lung Association of New Jersey, it has not gone through the Agency's publication review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred.

EFFECTIVE MARCH 2008
Permission to reproduce blank form
Approved by the New Jersey Thoracic Society

FOR MINORS ONLY:

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

PHYSICIAN/APN/PA SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP

Make a copy for patient and for physician file. For children under 18, send original to school nurse or child care provider.

New Jersey Department of Education ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the parent and student and reviewed by examining provider
Part B: PHYSICAL EVALUATION FORM-Completed by examining licensed provider with MD, DO, APN or PA

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____ Date of Last Sports Physical: _____

Student's Name: _____ Sex: M F (circle one) Age: ____ Grade: ____
 Date of Birth: ____/____/____ School: _____ District: _____
 Sport(s): _____ Home Phone: (____) _____
 Provider Name (Medical Home): _____ Phone: _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name of parent/guardian: _____ Relationship to student: _____
 Phone (work): _____ Phone (home): _____ Phone (cell): _____
 Additional emergency contact: _____ Relationship to student: _____
 Phone (work): _____ Phone (home): _____ Phone (cell): _____

Directions: Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

- 1. Have you ever had, or do you currently have:**
- a. Restriction from sports for a health related problem? Y / N / Don't Know
 - b. An injury or illness since your last exam? Y / N / Don't Know
 - c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know
 - (1.) An inhaler or other prescription medicine to control asthma? Y / N / Don't Know
 - d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know
 - e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
 - f. Any **allergies** to medications? **Y / N / Don't Know**
 - g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't Know
 - (1.) If yes, check type of reaction:
 - Rash Hives Breathing or other anaphylactic reaction
 - (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) Y / N / Don't Know
 - h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know
 - i. A blood relative who died before age 50? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

List all medications here:

Medication Name	Dosage	Frequency

2. **Have you ever had, or do you currently have, any of the following *head-related* conditions:**

- | | |
|---|--------------------|
| a. Concussion or head injury (including "bell rung" or a "ding")? | Y / N / Don't Know |
| b. Memory loss? | Y / N / Don't Know |
| c. Knocked out? | Y / N / Don't Know |
| c. A seizure? | Y / N / Don't Know |
| d. Frequent or severe headaches (With or without exercise)? | Y / N / Don't Know |
| e. Fuzzy or blurry vision | Y / N / Don't Know |
| f. Sensitivity to light/noise | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

3. **Have you ever had, or do you currently have, any of the following *heart-related* conditions:**

- | | |
|--|--------------------|
| a. Restriction from sports for heart problems? | Y / N / Don't Know |
| b. Chest pain or discomfort? | Y / N / Don't Know |
| c. Heart murmur? | Y / N / Don't Know |
| d. High blood pressure? | Y / N / Don't Know |
| e. Elevated cholesterol level? | Y / N / Don't Know |
| f. Heart infection? | Y / N / Don't Know |
| g. Dizziness or passing out during or after exercise without known cause? | Y / N / Don't Know |
| h. Has a provider ever ordered a heart test (EKG, echocardiogram, stress test, Holter monitor)? | Y / N / Don't Know |
| i. Racing or skipped heartbeats? | Y / N / Don't Know |
| j. Unexplained difficulty breathing or fatigue during exercise? | Y / N / Don't Know |
| k. Any family member (blood relative): | |
| (1.) Under age 50 with a heart condition? | Y / N / Don't Know |
| (2.) With Marfan Syndrome? | Y / N / Don't Know |
| (3.) Died of a heart problem before age 50? If yes, at what age? _____ | Y / N / Don't Know |
| (4.) Died with no known reason? | Y / N / Don't Know |
| (5.) Died while exercising? If yes, was it during or after? (Circle one.) | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

4. **Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat* conditions:**

- | | |
|---|--------------------|
| a. Vision problems? | Y / N / Don't Know |
| (1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.) | Y / N / Don't Know |
| b. Hearing loss or problems? | Y / N / Don't Know |
| (1.) Wear hearing aides or implants? | Y / N / Don't Know |
| c. Nasal fractures or frequent nose bleeds? | Y / N / Don't Know |
| d. Wear braces, retainer or protective mouth gear? | Y / N / Don't Know |
| e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

5. **Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic* conditions:**

- | | |
|---|--------------------|
| a. Numbness, a "burner", "stinger" or pinched nerve? | Y / N / Don't Know |
| b. A sprain? | Y / N / Don't Know |
| c. A strain? | Y / N / Don't Know |
| d. Swelling or pain in muscles, tendons, bones or joints? | Y / N / Don't Know |
| e. Dislocated joint(s)? | Y / N / Don't Know |
| f. Upper or lower back pain? | Y / N / Don't Know |
| g. Fracture(s), stress fracture(s), or broken bone(s)? | Y / N / Don't Know |
| h. Do you wear any protective braces or equipment? | Y / N / Don't Know |

Explain all (yes) answers here (include relevant dates):

6. Have you ever had or do you currently have any of the following *general or exercise related conditions*:

- a. Difficulty breathing?
 - (1.) During exercise? Y / N / Don't Know
 - (2.) After running one mile? Y / N / Don't Know
 - (3.) Coughing, wheezing or shortness of breath in weather changes? Y / N / Don't Know
 - (4.) Exercise-induced asthma? Y / N / Don't Know
 - i. Controlled with medication? (specify _____) Y / N / Don't Know
 - ii. Experience dizziness, passing out or fainting? Y / N / Don't Know
- b. Viral infections (e.g. mono, hepatitis, coxsackie virus)? Y / N / Don't Know
- c. Become tired more quickly than others? Y / N / Don't Know
- d. Any of the following skin conditions:
 - (1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts? Y / N / Don't Know
 - (2.) Sun sensitivity? Y / N / Don't Know
- e. Weight gain/loss (of 10 pounds or more)? Y / N / Don't Know
 - (1.) Do you want to weigh more or less than you do now? Y / N / Don't Know
- f. Ever had feelings of depression? Y / N / Don't Know
- g. Heat-related problems (dehydration, dizziness, fatigue, headache)? Y / N / Don't Know
 - (1.) Heat exhaustion (cool, clammy, damp skin)? Y / N / Don't Know
 - (2.) Heat stroke (hot, red, dry skin)? Y / N / Don't Know
 - (3.) Muscle cramps? Y / N / Don't Know
- h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

7. **Females only:**

Age of onset of menstruation: _____ How many menstrual periods in the last twelve (12) months? _____

How many periods missed in the last twelve (12) months? _____

8. **Males only:**

Have you had any swelling or pain in your testicles or groin? Y / N / Don't Know

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Signature, Parent/Guardian or Student Age 18

Date of Signature:

THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.

ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

Part B: Physical Evaluation Form

(Completed by the examining licensed provider MD, DO, APN or PA)

-STUDENT INFORMATION-

Student's Name: _____ Sport(s): _____
 Sex: M F (circle one) Age: _____ Grade: _____ Date of Birth: _____
 Address: _____
 City/State/Zip: _____ Home Phone: _____
 School: _____ District: _____
 Parent/Guardian's Full Name: _____

- EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

If conducted by school physician check here

Name: _____ Phone: _____ Fax: _____
 Address: _____ City/State/Zip: _____

- FINDINGS OF PHYSICAL EVALUATION -

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____ bpm.
 Vision: R 20/____ L 20/____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it: Louder Softer No Change Squatting makes it: Louder Softer No Change Valsalva makes it: Louder Softer No Change
Femoral Pulses	YES	
Lungs: Auscultation/Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Assessment of physical maturation or Tanner Scale	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	
Hernia	ABSENT	
Evidence of Marfan Syndrome	ABSENT	

Most recent immunizations and dates administered:

Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Additional observations:

General Diagnosis:

General Recommendations:

THE HISTORY PREPARED BY THE PARENT/STUDENT MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE PHYSICAL EXAMINATION.

CLEARANCES: This section is completed by the examining healthcare provider.

After examining the student and reviewing the medical history the student is:

- A. Cleared for participation in all sports without restrictions.
- B. Not cleared for participation in any sport until evaluation/treatment of:

- C. Cleared for limited participation in the following types of sports only. Please see below for sport classifications. CHECK ALL THAT APPLY

___ CONTACT/COLLISION
___ LIMITED CONTACT

___ NON-CONTACT/STRENUOUS
___ NON-CONTACT/NON-STRENUOUS

Limitations due to: _____

NOTES TO THE EXAMINING PROVIDER

Conditions requiring clearance before sports participation include, but are not limited to the following:

Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly; Splenomegaly; Malignancy; Seizure Disorder; Marfan's Syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Basketball	Baseball	Discus	Bowling
Diving	Cheerleading	Javelin	Golf
Field Hockey	Fencing	Shot put	
Football	High Jump	Rowing	
Ice Hockey	Pole vault	Running/Cross Country	
Lacrosse	Gymnastics	Strength Training	
Soccer	Skiing	Swimming	
Wrestling	Softball	Tennis	
	Volleyball	Track	

Effects of physiologic maneuvers on heart sounds

Standing Increases murmur of HCM
Decreases murmur of AS, MR
MVP click occurs earlier in systole

Squatting Increases murmur of AS, MR, AI
Decreases murmur of MCH
MVP click delayed

Valsalva Increases murmur of HCM
Decreases murmur of AS, MR
MVP click occurs earlier in systole

Physical Stigmata of Marfan's Syndrome

Kyphosis
High arched palate
Pectus excavatum
Arachnodactyly
Arm span > height 1.05:1 or greater
Mitral Valve Prolapse
Aortic Insufficiency
Myopia
Lenticular dislocation

HCM: Hypertrophic Cardio Myopathy
AS: Aortic Stenosis
AI: Aortic Insufficiency
MR: Mitral Regugitation
MVP: Mitral Valve Prolapse

HISTORY REVIEWED AND STUDENT EXAMINED BY: Physician's/Provider's Stamp:

- Primary Care Provider
- School Physician Provider
- License Type:
 - MD/DO
 - APN
 - PA

PHYSICIAN'S/PROVIDER'S SIGNATURE: _____

Today's Date: _____

Date of Exam: _____

RESERVED FOR SCHOOL DISTRICT USE

NOTE: *N.J.A.C. 6A:16-2.2* requires the school physician to provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this physical evaluation. This evaluation and the notification letter become part of the student's school health record.

History and Physical Reviewed By: _____ Date: _____

Title of Reviewer (please check one): School Nurse School Physician

Medical Eligibility Notification Sent to Parent/Guardian by School Physician _____
Date

Letter of notification is attached.

OR

Parent notification indicates that:

- Participation Approved without limitations.
- Participation Approved with limitations pending evaluation.
- Participation NOT Approved

Reason(s) for Disapproval: _____

HIGH SCHOOL ONLY

NAME OF ATHLETE

SPORT

SCHOOL YEAR

NJSIAA STEROID TESTING POLICY

CONSENT TO RANDOM TESTING

In Executive Order 72, issued December 20, 2005, Governor Richard Codey directed the New Jersey Department of Education to work in conjunction with the New Jersey State Interscholastic Athletic Association (NJSIAA) to develop and implement a program of random testing for steroids, of teams and individuals qualifying for championship games.

Beginning In the Fall, 2006 sports season, any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances on the attached page, without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition. The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents, and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing.

By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

Print name of student-athlete

Signature of student-athlete

Date

Print name of parent/guardian

Signature of parent/guardian

Date

HIGH SCHOOL ONLY

NJSIAA Banned-Drug Classes

The term "related compounds" comprises substances that are included in the class by their pharmacological action and/or chemical structure. No substance belonging to the prohibited class may be used, regardless of whether it is specifically listed as an example.

Many nutritional/dietary supplements contain NJSIAA banned substances. In addition, the U. S. Food and Drug Administration (FDA) does not strictly regulate the supplement industry; therefore purity and safety of nutritional dietary supplements cannot be guaranteed. Impure supplements may lead to a positive NJSIAA drug test. The use of supplements is at the student-athlete's own risk. Student-athletes should contact their physician or athletic trainer for further information.

The following is a list of banned-drug classes, with examples of banned substances under each class:

<p>(a) Stimulants amiphenazole amphetamine bemigrade benzphetamine bromantan caffeine ¹ (guarana) chlorphentermine cocaine cropropamide crothetamide diethylpropion dimethylamphetamine doxapram ephedrine (ephedra, ma huang) ethamivan ethylamphetamine fencamfamine meclofenoxate methamphetamine methylenedioxyamphetamine (MDMA, ecstasy) Methylphenidate Nikethamide Pemoline Pentetrazol Phenmetrazine</p>	<p>Phentermine phenylpropanolamine (ppa) picrotoxine pipradol prolintane strychnine synephrine (citrus aurantium, zhi shi, bitter orange) and related compound</p> <p>(b) Anabolic Agents <u>anabolic steroids</u> androstenediol androstenedione boldenone clostebol dehydrochlormethyl- testosterone dehydroepiandro- sterone (DHEA) dihydrotestosterone (DHT) dromostanolone epitrenbolone fluoxymesterone gestrinone</p>	<p>mesterolone methandienone methenolone methyltestosterone nandrolone norandrostenediol norandrostenedione norethandrolone oxandrolone oxymesterone oxymetholone phendimetrazine pregnelone stanozolol testosterone² tetrahydrogestrinon (THG) trenbolon and related compounds</p> <p><u>other anabolic agents</u> clenbuterol</p> <p>(c) Diuretics Acetazolamide Bendroflumethiazide benzhiazide bumetanide</p>	<p>chlorothiazide chlorthalidone ethacrynic acid f1umethiazide furosemide hydrochlorothiazide hydroflumethiazide methyclothiazide metolazone polythiazide quinethazone spironolactone triamterene trichlormethiazide and related compounds</p> <p>(d) Peptide Hormones & Analogues: corticotrophin (ACTH) human chorionic gonadotrophin (hCG) leutenizing hormone (LH) growth hormone (HGH, somatotrophin) insulin like growth hormone (IGF-1)</p> <p>All the respective releasing factors of the above-mentioned substances also are banned: erythropoietin (EPO) darbypoetin sermorelin</p>
--	--	--	--

(e) Definitions of positive depends on the following:

1 for caffeine - if the concentration in urine exceeds 15 micrograms/ml

2 for testosterone - if administration of testosterone or use of any other manipulation has the result of increasing the ratio of the total concentration of testosterone to that of epitestosterone in the urine of greater than 6:1, unless there is evidence that this ratio is due to a physiological or pathological condition.