

**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.**
- ❖ 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.**
- ❖ 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.**
- ❖ Complete and have the parent/guardian and student sign the **Part A Health History Questionnaire. 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** 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. HIGH SCHOOL ONLY**
- ❖ Please read the **NJSIAA Banned-Drug Classes** sheet. **HIGH SCHOOL ONLY**
- ❖ Please read the **NJSIAA Parent/Guardian Concussion Policy Acknowledgement Form** and sign in appropriate spaces.
  
- ❖ **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>
○ <b>Fall - June 30<sup>th</sup> - August 2<sup>nd</sup></b>	<b>Fall – July 15<sup>th</sup> – August 20<sup>th</sup></b>
○ <b>Winter – September 30<sup>th</sup> - November 2<sup>nd</sup></b>	<b>Winter – September 30<sup>th</sup> - November 2<sup>nd</sup></b>
○ <b>Spring – January 6<sup>th</sup> - February 2<sup>nd</sup></b>	<b>Spring – January 6<sup>th</sup> – February 2<sup>nd</sup></b>

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**

- | <u>Parent/Guardian check</u>                                                                                                                                                                                                 | <u>School check</u>      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|
| <input type="checkbox"/> Athletic Emergency Information Form (new form needed for each sport season)                                                                                                                         | <input type="checkbox"/> |
| <input type="checkbox"/> Permission To Engage in Athletics (new form needed for each sport season)                                                                                                                           | <input type="checkbox"/> |
| <input type="checkbox"/> Asthma Awareness Questionnaire (date within 60 days prior to each sport)                                                                                                                            | <input type="checkbox"/> |
| <input type="checkbox"/> Asthma Treatment Plan (once a year if applicable)                                                                                                                                                   | <input type="checkbox"/> |
| <input type="checkbox"/> Part A: PARENT Health History Questionnaire (date within 60 days prior to each sport) (review with physician at yearly physical)                                                                    | <input type="checkbox"/> |
| <input type="checkbox"/> 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) | <input type="checkbox"/> |

**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 30<sup>th</sup> - August 2<sup>nd</sup>  
WINTER - September 30<sup>th</sup> - November 2<sup>nd</sup>  
SPRING - January 10<sup>th</sup> - February 2<sup>nd</sup>

**Middle School Due Dates**

FALL - July 15<sup>th</sup>- August 20<sup>th</sup>  
WINTER - September 30<sup>th</sup>- November 2<sup>nd</sup>  
SPRING - January 10<sup>th</sup> - February 2<sup>nd</sup>

**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

**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	

## 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:
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

And/or Peak flow above \_\_\_\_\_

Remember to rinse your mouth after taking inhaled medicine.

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

## CAUTION



You have **any** of these:

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

**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.

And/or Peak flow from \_\_\_\_\_ to \_\_\_\_\_

## 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

**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	

And/or Peak flow below \_\_\_\_\_

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 operated by grant from the New Jersey Department of Health and Senior Services (NJHSS), with funds provided by the U.S. Centers for Disease Control and Prevention (CDC) under Cooperative Agreement 5U49CE000500. All contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC or the USDOH.

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**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 HEALTH HISTORY QUESTIONNAIRE

**HEALTH HISTORY QUESTIONNAIRE**-Completed by the parent and student and reviewed by examining provider when physical exam is indicated.

## HEALTH HISTORY QUESTIONNAIRE

Today's Date: \_\_\_\_\_

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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: \_\_\_\_\_

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### 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): \_\_\_\_\_

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**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):

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**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):

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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):

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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):

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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):

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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):

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**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.**

**New Jersey Department of Education**  
**COMPREHENSIVE PHYSICAL EXAMINATION 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,	YES	

Stability)		
Neurological: Balance & Coordination	YES	
Hernia	ABSENT	
Evidence of Marfan Syndrome	ABSENT	

**Most recent immunizations and dates administered:**

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**Medications currently prescribed, with dose and frequency:**

Medication Name	Dosage	Frequency

**Additional observations:**

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**General Diagnosis:**

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**General Recommendations:**

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

**CLEARANCES: (See notes at bottom for conditions requiring attention and for a list of sports by level of contact)**

- A.** Student is cleared for participation in **all** sports without restriction.
- B.** Student is **withheld clearance** for participation in any sport until evaluation / treatment of:

\_\_\_\_\_  
\_\_\_\_\_

- C.** Student is cleared for participation in **limited types** of sports which **exclude** the following types of sports contact: (CHECK ALL THAT APPLY)

- CONTACT/COLLISION
- LIMITED CONTACT
- NON-CONTACT/STRENUOUS
- NON-CONTACT/NON-STRENUOUS

Due to: \_\_\_\_\_

**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: \_\_\_\_\_

**HISTORY REVIEWED BY:**

Name \_\_\_\_\_ Today's Date: \_\_\_\_\_  
SIGNATURE: \_\_\_\_\_ Review Date: \_\_\_\_\_

**RESERVED FOR SCHOOL DISTRICT USE**

## 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 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	

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.

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 Regurgitation

MVP = Mitral Valve Prolapse

# HIGH SCHOOL ONLY

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NAME OF ATHLETE

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SPORT

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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.

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Print name of student-athlete

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Signature of student-athlete

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Date

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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><b>(a) Stimulants</b>            amiphenazole            amphetamine            bemigrade            benzphetamine            bromantan            caffeine<sup>1</sup> (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)  <b>and            related            compound</b></p> <p><b>(b) Anabolic Agents</b>  <u><b>anabolic steroids</b></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            testosterone<sup>2</sup>            tetrahydrogestrinon            (THG)            trenbolon  <b>and related compounds</b></p> <p><u><b>other anabolic agents</b></u>            clenbuterol</p> <p><b>(c) Diuretics</b>            Acetazolamide            Bendroflumethiazide            benzhiazide            bumetanide</p>	<p>chlorothiazide            chlorthalidone            ethacrynic acid            f1umethiazide            furosemide            hydrochlorothiazide            hydroflumethiazide            methyclothiazide            metolazone            polythiazide            quinethazone            spironolactone            triamterene            trichlormethiazide  <b>and related compounds</b></p> <p><b>(d) Peptide Hormones &amp; Analogues:</b>            corticotrophin (ACTH)            human chorionic gonadotrophin (hCG)            leutenizing hormone (LH)            growth hormone (HGH, somatotrophin)            insulin like growth hormone (IGF-1)</p> <p><b>All the respective releasing factors of            the above-mentioned substances            also are banned:</b>            erythropoietin (EPO)            darbypoetin            sermorelin</p>
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(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.



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## **NJSIAA PARENT/GUARDIAN CONCUSSION POLICY ACKNOWLEDGMENT FORM**

In order to help protect the student athletes of New Jersey, the NJSIAA has mandated that all athletes, parents/guardians and coaches follow the NJSIAA Concussion Policy.

A concussion is a brain injury and all brain injuries are serious. They may be caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a “ding” or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child/player reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

### **Symptoms may include one or more of the following:**

1. Headache.
2. Nausea/vomiting.
3. Balance problems or dizziness.
4. Double vision or changes in vision.
5. Sensitivity to light or sound/noise.
6. Feeling of sluggishness or fogginess.
7. Difficulty with concentration, short-term memory, and/or confusion.
8. Irritability or agitation.
9. Depression or anxiety.
10. Sleep disturbance.

### **Signs observed by teammates, parents and coaches include:**

1. Appears dazed, stunned, or disoriented.
2. Forgets plays or demonstrates short-term memory difficulties (e.g. is unsure of the game, score, or opponent)
3. Exhibits difficulties with balance or coordination.
4. Answers questions slowly or inaccurately.
5. Loses consciousness.
6. Demonstrates behavior or personality changes.
7. Is unable to recall events prior to or after the hit.

**What can happen if my child/player keeps on playing with a concussion or returns too soon?**

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete's safety.

**If you think your child/player has suffered a concussion**

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear. Close observation of the athlete should continue for several hours.

An athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time and may not return to play until the athlete is evaluated by a medical doctor or doctor of Osteopathy, trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider.

You should also inform you child's Coach, Athletic Trainer (ATC), and/or Athletic Director, if you think that your child/player may have a concussion. And when it doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:

<http://www.cdc.gov/ConcussionInYouthSports/>

[www.nfhslearn.com](http://www.nfhslearn.com)

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Print Student-Athlete's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Print Parent/Guardian's Name

\_\_\_\_\_  
Date

Please keep this form on file at the school. Do not return to the NJSIAA. Thank you.