Athletes Name: _____

No physical will be accepted unless all necessary required steps are completed.

_____Registered On Line

_____Completed Physical

_____Health Update Form if Physical is more than 90 days old.

_____9th, 11th and transfer students Receipt from Im Pact baseline test

_____Any Emergency Health Care Plans (asthma, Epi or Diabetes)

Parent Signature_____
Date:_____

Date Received

West Morris Regional High School District
Emergency Health Care Plan

Name:_____ D.O.B:_____ Grade:_____

Allergy/Anaphylaxis to: _____

Asthmatic: Yes ❑ No ❑ (High Risk for Severe Reaction).
Student Responsible and Approved by MD/Parent to Self Carry and Administer
Epi-pen (and Benedryl if ordered) Yes ❑ No ❑
Student carries Epi-Pen with him: Yes ❑ No ❑
Locations of Epi-Pen: _____
Has student ever had an anaphylactic reaction? Yes ❑ No ❑

Signs Of an Allergic Reaction Include:
(Please check the specific symptoms which this student has experienced).

	Systems	**Symptoms**
❑	Mouth	itching, swelling of lips, tongue or mouth
❑	Throat	itching, tightness of throat, hoarseness, and hacking cough
❑	Skin	hives, itchy rash, swelling of face and or extremities, sweating
❑	Gut	nausea, abdominal cramps, vomiting, and or diarrhea
❑	Lung	shortness of breath, repetitive coughing, and or wheezing
❑	General anxiety	

The severity of symptoms can quickly change. All the above symptoms can potentially progress to a life-threatening situation!!

Action for Suspected Ingestion/Sting:

1. Immediately administer:_____
   and then administer_____.
   May administer 2nd epinephrine injection after _____ minutes.
2. Call Rescue Squad. Stay with student.
3. Call Mother _____ Father _____

Emergency contacts:

Name _____ Phone _____
Name _____ Phone _____
Dr. _____ Phone _____

Do not hesitate to administer the medication or call rescue squad even if parents can not be reached.

_____ _____
Parent signature Date

_____ _____
MD signature (Please Stamp) Date

West Morris Central High School

Health Office

Phone: 908-879-5212 ext. 3495 Fax: 908-879-5460
E-mail: smoor@wmrhsd.org / ckaminski@wmrhsd.org

Dear Parent/Guardian,

The protocols for the administration of **Epinephrine** for life threatening allergies. According to P.L. 2007.57 (S79 2R), delegates for epinephrine for school need written permission from the parent. Accompanying permission from the parent must be a current copy of the student's Emergency Care Plan for **Epinephrine** Auto Injector.
A separate **Epineprine** Auto Injector must be provided by the guardian for the purpose of the delegate's access in the event of an emergency. If not provided a delegate cannot be assigned.
Take note that this form must be returned to the school nurse to keep a record of your wishes to be in compliance with New Jersey code.
The nurse must be informed of field trips or after school activities within 72 hours to make arrangements for trained delegates to cover these activities.
(The parent will be notified in the event that a nurse or delegate cannot be assigned for the off campus activity during school hours. Weekend trips require notice as soon as possible to accommodate your request).

Sincerely,
Cathe Kaminski, RN
Susan Moor, RN

Epinephrine Auto Injector Permission

Student Name: _____ Grade: _____

(Check all that apply)

❑ I give permission
❑ I do not give permission
❑ My son/daughter has permission to self manage their allergy and administer their dose of Benedryl and or epinephrine. I do not need a delegate or nurse assigned in the event one is not available.

My child's Emergency Care Plan is enclosed to reflect my request for his/her medical care.
I understand that by giving permission for a delegate to be assigned that by child's medical information will be shared with pertinent staff members to ensure proper care of my son/daughter.

The volunteer delegate is trained by the school nurse and may administer **Epinephrine** in the event of an emergency for anaphylaxis in which the school nurse or parent is not available for the _____ school year.
I understand that the district and its agents are acting in good faith and the delegate shall be immune from any civil or criminal liability arising from actions pursuant to this act.

_____ _____
Parent Signature Date

West Morris Central High School

Health Office

Phone: 908-879-5212 ext. 3495 Fax: 908-879-5460
E-mail: smoor@wmrhsd.org / ckaminski@wmrhsd.org

Dear Parent/Guardian:

According to regulations which govern us, **SELF-ADMINISTRATION** of any medication by school children is not permitted except in cases of severe asthma or other potentially life-threatening illness. We must have written authorization from the physician and the parent or guardian.

Permission for medication is effective only for the current school year and needs to be renewed for each subsequent school year.

Kindly complete the attached form and have your child return it to the Health Office. Thank you. Please let us know if your child no longer needs to use an **inhaler** or **EpiPen**. (See below)

Sincerely,
Cathe Kaminski, RN
Susan Moor, RN

REQUEST FOR TREATMENT

PHYSICIAN:

I am treating _____ for _____
student name condition/illness

and prescribe the following medication/treatment _____.

I acknowledge that this pupil is capable of and has been instructed in the proper method of self-administration of this medication.

Date: _____ Doctor's Signature: _____.
(PLEASE STAMP)

PARENT:

I request that my child _____ be permitted to self-medicate as

prescribed above for the following condition: _____.

I acknowledge that the West Morris Regional Board of Education shall incur no liability as a result of any injury arising from self-administration of medication by the pupil and that we the parents shall indemnify and hold harmless the district and its employees against any claims arising out of the self-medication by the pupil.

Date: _____ Parent's Signature: _____

☐ My child no longer has a need for an inhaler and/or EpiPen _____
Parent Signature

MANDATORY IMPACT CONCUSSION BASELINE TESTING FOR ALL ATHLETES

As you know, **all** students interested in participating in the sports and /or cheerleading programs must complete a physical prior to activity. At WMCHS, we also require each athlete/cheerleader to obtain a baseline score on the ImPact test for concussion management. This test is a computerized one that scores reaction time, memory, recall, and processing speeds. **A baseline test will be obtained ONCE EVERY 2 YEARS (usually FRESHMAN and JUNIOR years.) IT DOES NOT NEED TO BE RE-TAKEN EVERY SEASON.** The test will only need to be re-administered if the student athlete suffers a head injury during the season. The results of this test will be one piece of a puzzle that will be used to clear an athlete for activity. This does not replace the care of a physician, but does assist in the return to play decision. No one wants to see an athlete return to activity before he/she is ready.

THIS TEST MUST BE COMPLETED PRIOR TO YOUR PHYSICAL. PRINT/SAVE THE CONFIRMATION FORM/RECEIPT AFTER COMPLETING THE TEST. THE HARD COPY OF THE RECEIPT/CONFIRMATION FORM MUST BE SUBMITTED WITH YOUR PHYSICAL FORMS TO THE NURSES.

You can take the test at home. Once you have completed the test, the results will be sent to a special website that the athletic trainer will be able to reference.

The most important part of the test is to follow the directions and pay attention. If you do not pay attention or try to lower your score on purpose your test scores will come up invalid and you will have to take the test again. There is no pass or fail, but results are compared to national norms for specific age groups, so try your best. This is not an easy test, but realize it is a baseline only. Do not worry if you see the word "incorrect" come up when answering questions. **Just do your best!**

To take the test, you must have a computer with an external mouse. If you are using a laptop make sure it is plugged in so the battery does not die while taking the test. The entire test should take approximately 30 minutes. The room must be quiet. **No radios, talking, texting, phone calls, etc.** The test is timed, if something diverts your attention you will probably get an invalid score.

To take the baseline test go to www.impacttestonline.com/schools **The ID code for WMC is D1727C86E2.** This site is for a baseline only. **Do not** go to this site again after taking the test. All post injury tests will be done with the athletic trainer on another site.

Some helpful hints:

1. Make sure the pop off blocker is off on your computer.
2. For the number of years of education, answer 8 for freshmen and 10 for juniors.
3. If you have not suffered from a recent concussion, your response for each symptom question should be zero or not experiencing at this time.

If you have any questions, contact Suzanne Barba, Athletic Trainer at sbarba@wmrhsd.org

West Morris Central High School

Health Office

Phone: 908-879-5212 ext. 3495 Fax: 908-879-5460
E-mail: smoor@wmrhsd.org / ckaminski@wmrhsd.org

Dear Parent/Guardian:

According to regulations which govern us, **SELF-ADMINISTRATION** of any medication by school children is not permitted except in cases of severe asthma or other potentially life-threatening illness. We must have written authorization from the physician and the parent or guardian.

Permission for medication is effective only for the current school year and needs to be renewed for each subsequent school year.

Kindly complete the attached form and have your child return it to the Health Office. Thank you. Please let us know if your child no longer needs to use an **inhaler** or **EpiPen**. (See below)

Sincerely,
Cathe Kaminski, RN
Susan Moor, RN

REQUEST FOR TREATMENT

PHYSICIAN:

I am treating _____ for _____
student name condition/illness

and prescribe the following medication/treatment _____.

I acknowledge that this pupil is capable of and has been instructed in the proper method of self-administration of this medication.

Date: _____ Doctor's Signature: _____.
(PLEASE STAMP)

PARENT:

I request that my child _____ be permitted to self-medicate as

prescribed above for the following condition: _____.

I acknowledge that the West Morris Regional Board of Education shall incur no liability as a result of any injury arising from self-administration of medication by the pupil and that we the parents shall indemnify and hold harmless the district and its employees against any claims arising out of the self-medication by the pupil.

Date: _____ Parent's Signature: _____

☐ My child no longer has a need for an inhaler and/or EpiPen _____
Parent Signature

Asthma and Allergy Foundation of America

CHILD CARE ASTHMA/ALLERGY ACTION CARD

EPA

ID Photo

Name: _____

Grade: _____ DOB: _____

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ (W): _____

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ (W): _____

Other Contact Information: _____

Emergency Phone Contact #1 _____
Name

_____ _____
Relationship Phone

Emergency Phone Contact #2 _____
Name

_____ _____
Relationship Phone

Physician Child Sees for Asthma/Allergies: _____

Phone: _____

Other Physician: _____

Phone: _____

DAILY ASTHMA/ALLERGY MANAGEMENT PLAN

- **Identify the things that start an asthma/allergy episode**
  (Check each that applies to the child)

— Animals — Bee/Insect Sting — Chalk Dust — Change in Temperature
— Dust Mites — Exercise — Latex — Molds
— Pollens — Respiratory Infections — Smoke — Strong Odors
— Food: _____
— Other: _____
Comments: _____

- **Peak Flow Monitoring** (for children over 4 years old)

Personal Best Peak Flow reading: _____
Monitoring Times: _____ _____ _____

- **Control of Child Care Environment** (List any environmental control measures, pre-medications, and/or dietary restrictions that the child needs to prevent an asthma/allergy episode.) _____

- **Daily Medication Plan for Asthma/Allergy**

	Name	Amount	When to Use
1			
2			
3			
4			

OUTSIDE ACTIVITY AND FIELD TRIPS

The following medications must accompany child when participating in outside activity and field trips:

	Name	Amount	When to Use
1			
2			
3			

Rev. 5/01

ASTHMA EMERGENCY PLAN

Emergency action is necessary when the child has symptoms such as _____

_____

or has a peak flow reading at or below _____

- **Steps to take during an asthma episode:**
  1. Check peak flow reading (if child uses a peak flow meter).
  2. Give medications as listed below.
  3. Check for decreased symptoms and/or increased peak flow reading.
  4. Allow child to stay at child care setting if: _____

     _____
  5. Contact parent/guardian
  6. Seek emergency medical care if the child has any one of the following:

→ No improvement minutes after initial treatment with medication.
→ Peak flow at or below _____.
→ Hard time breathing with:
  - Chest and neck pulled in with breathing.
  - Child hunched over.
  - Child struggling to breathe.

→ Trouble walking or talking.
→ Stops playing and cannot start activity again.
→ Lips or fingernails are gray or blue.

IF THIS HAPPENS, GET EMERGENCY HELP NOW!

ALLERGY EMERGENCY PLAN

- **Child is allergic to:** _____

  _____

  _____
- **Steps to take during an allergy episode:**
  1. If the following symptoms occur, give the medications listed below.
  2. Contact Emergency help and request epinephrine.
  3. Contact the child's parent/guardian.
- **Symptoms of an allergic reaction include:**

  (Physician, please circle those that apply)

→**Mouth/Throat:** itching & swelling of lips, tongue, mouth, throat; throat tightness; hoarseness; cough
→**Skin:** hives; itchy rash; swelling
→**Gut:** nausea; abdominal cramps; vomiting; diarrhea
→**Lung*:** shortness of breath; coughing; wheezing
→**Heart:** pulse is hard to detect; "passing out"
*If child has asthma, asthma symptoms may also need to be treated.

- **Emergency Asthma Medications:**

	Name	Amount	When to Use
1			
2			
3			
4			

- **Emergency Allergy Medications:**

	Name	Amount	When to Use
1			
2			
3			
4			

- **Special Instructions:**

  _____

  _____
- **Special Instructions:**

  _____

  _____

Physician's Signature **Date** **Parent/Guardian's Signature** **Date** **Child Care Provider's Signature** **Date**

ATTENTION PARENT/GUARDIAN: The preparticiaption 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
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
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)?		
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?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
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)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
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 _____

HE0503 9-2681/0410

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

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 _____

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

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practician 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

1. **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?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

EXAMINATION		
Height Weight	☐ Male ☐ Female	
BP / (/) Pulse	Vision R 20/ L 20/	Corrected ☐ Y ☐ 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		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider 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 _____

HE0503 9-2681/0410

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

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 _____

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

State of New Jersey
DEPARTMENT OF EDUCATION

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