ELIZABETH C. JEWETT, PHD
SUPERINTENDENT

TIMOTHY M. STYS, CPA
BUSINESS ADMINISTRATOR

WILLIAM J. LIBRERA
PRINCIPAL

WATCHUNG HILLS
REGIONAL HIGH SCHOOL

IMPORTANT- **PARENT AND PHYSICIAN** PLEASE READ

Student Name _____ **Grade**_____

Date of Birth _____ **Sex** _____ **Sport**_____

Address _____

Parent Email _____ **Best Contact #** _____

Second Contact Name and #_____

DATE OF EXAM _____

The NJ Department of Education requires this form be used for all sport physical examinations (PPE). The PPE may only be completed by a licensed physician, advanced practice nurse (APN) or physician assistant (PA) that has completed the Student-Athlete Cardiac Assessment professional development module. It is recommended that you verify that your medical provider has completed this module before schedule an appointment for a PPE.

Before you leave the physician's office, the following checklist should be reviewed to ensure that your physical is complete. Our school physician will not approve/clear your physical unless all pages are completed in full and correctly.

Parent Section-History Form and Supplemental History Form

- ☐ Student demographic information is complete
- ☐ Medicine and Allergy information is complete.
- ☐ All questions are answered on the history form
- ☐ YES answers are explained completely, where indicated, on both pages.
- ☐ Athlete & Parent signature and date are completed on both pages.

Physician Section-Physical Examination Form and Clearance Form

- ☐ ALL Physical Findings (height, weight, BP, pulse and **VISION**) are filled out by the physician. Vision may not say "Declined, Sees Eye Doctor, or Done in School."
- ☐ Clearance, Physician's signature and date of exam are completed on both pages.
- ☐ Physician signature/date indicating completion of the Student-Athlete Cardiac Assessment Professional Development Module.

Your Physical (PPE) will not be processed and returned to you if all information is not complete.

Please make a copy of your physical for your records.

New Jersey Department of Education
Health History Update Questionnaire

Name of School: _____

NEW: This form (page 2) must be completed and signed by the parent/guardian and included in the complete sports physical packet that is signed by the student's physician.

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 ☐ No ☐
9. Started or stopped taking any over-the-counter or prescribed medications? Yes ☐ No ☐
10. Been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐
    If diagnosed with Coronavirus (COVID-19), was your son/daughter symptomatic? Yes ☐ No ☐
    If diagnosed with Coronavirus (COVID-19), was your son/daughter hospitalized? Yes ☐ No ☐
11. Has any member of the student-athlete's household been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

Date: _____ Signature of parent/guardian.: _____

Please Return Completed Form to the School Nurse's Office

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

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

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

Date of Exam _____

Name _____ Date of birth _____

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

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

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL QUESTIONS	Yes	No
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 3-2681/0410

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 _____

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

Athletic Parental Consent Form

Student's Name_____**Grade**_____

Sport _____**School Year**_____

CONSENT

I/we hereby give consent to my son/daughter to participate in the above listed interscholastic sports program during the above listed school year. I/we also give permission for **Emergency Medical Treatment** by the team physician, school nurse, athletic trainer, hospital, and allied medical personnel for conditions arising in athletics. I/We understand that this includes initial and post injury treatment. This includes, but is not limited to: hot/cold modalities, electrical stimulation, ultrasound, muscle strengthening and exercise to increase range of motion and agility. I/We also give permission for preventative care including taping and bracing. I/We also give permission to allow the Athletic Training staff and treating physician to exchange information relating to a specific injury and/or medical condition. This exchange can be in the form of a facsimile, email, or verbal conversation. I/we realize that such activity involves the potential for injury that 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 school 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. Further, I/ we will not hold Watchung Hills Regional School District, or its representatives responsible in any way for injuries that may occur to my son/daughter because of his/her participation in the sport listed above.

Further, I/we also give permission for medical information regarding my son/daughter to be shared between the districts physician, nurse, athletic trainer, athletic director, and coach.

Please circle ALL that apply:

Asthma: Yes/No

Carries Inhaler : Yes/No

Severe Food/Drug Allergy: Yes/No

Carries Epi-Pen/Benadryl: Yes/No

Name of Food/Drug Allergic to:_____

Diabetes: Yes/No Carries Medication/Snack: Yes/No

Seizure Disorder: Yes/No Rescue medication: Yes/No

Cardiac Issue: Yes/No Please explain:_____

Any other medical concern: _____

Please explain in detail:

_____

_____

_____ _____

Signature Parent/Guardian Date