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 copy of this form in the chart.)

Date of Exam ____________________________ Date of birth ____________________________

Name ____________________________ 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

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No

2. Do you have any ongoing medical conditions? If so, please identify below: □ Asthma □ Aneurysm □ Diabetes □ Infections □ Other: ____________________________

3. Have you ever spent the night in the hospital? Yes No

4. Have you ever had surgery? Yes No

HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever passed out or nearly passed out during or after exercise? Yes No

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? Yes No

7. Does your heart ever race or skip beats (irregular beats) during exercise? Yes No

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) Yes No

10. Do you get lightheaded or feel more short of breath than expected during exercise? Yes No

11. Have you ever had an unexplained seizure? Yes No

12. Do you get more tired or short of breath more quickly than your friends during exercise? Yes No

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

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)? Yes No

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? Yes No

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Yes No

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? Yes No

BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? Yes No

18. Have you ever had any broken or fractured bones or dislocated joints? Yes No

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? Yes No

20. Have you ever had a stress fracture? Yes No

21. Have you ever been told that you have or you have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) Yes No

22. Do you regularly use a brace, orthotics, or other assistive device? Yes No

23. Do you have a bone, muscle, or joint injury that bothers you? Yes No

24. Do any of your joints become painful, swollen, feel warm, or look red? Yes No

25. Do you have any history of juvenile arthritis or connective tissue disease? Yes No

MEDICAL QUESTIONS

26. Do you cough, wheeze, or have difficulty breathing during or after exercise? Yes No

27. Have you ever used an inhaler or taken asthma medicine? Yes No

28. Is there anyone in your family who has asthma? Yes No

29. Were you born without or are you missing a kidney, an eye, a testicle (male), your bladder, or any other organ? Yes No

30. Do you have groin pain or a painful bulge or hernia in the groin area? Yes No

31. Have you had infectious mononucleosis (mono) within the last month? Yes No

32. Do you have any rashes, pressure sores, or other skin problems? Yes No

33. Have you had a herpes or MRSA skin infection? Yes No

34. Have you ever had a head injury or concussion? Yes No

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? Yes No

36. Do you have a history of seizure disorder? Yes No

37. Do you have headaches with exercise? Yes No

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? Yes No

39. Have you ever been unable to move your arms or legs after being hit or falling? Yes No

40. Have you ever become ill while exercising in the heat? Yes No

41. Do you get frequent muscle cramps when exercising? Yes No

42. Do you or someone in your family have sickle cell trait or disease? Yes No

43. Have you had any problems with your eyes or vision? Yes No

44. Have you had any eye injuries? Yes No

45. Do you wear glasses or contact lenses? Yes No

46. Do you wear protective eyewear, such as goggles or a face shield? Yes No

47. Do you worry about your weight? Yes No

48. Are you trying to or has anyone recommended that you gain or lose weight? Yes No

49. Are you on a special diet or do you avoid certain types of foods? Yes No

50. Have you ever had an eating disorder? Yes No

51. Do you have any concerns that you would like to discuss with a doctor? Yes No

FEMALES ONLY

52. Have you ever had a menstrual period? Yes No

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 ____________________________


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

S-20150410
The Athlete with Special Needs: Supplemental History Form

Date of Exam ______________________________ Date of birth ______________________________

Name ______________________________ Grade ______________________________ School ______________________________

1. Type of disabili ty
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trust, other)
5. List the sports you are interested in playing

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Do you regularly use a brace, assistive device, or prosthetic?</td>
<td></td>
</tr>
<tr>
<td>7. Do you use any special brace or assistive device for sports?</td>
<td></td>
</tr>
<tr>
<td>8. Do you have any rashes, pressure sores, or any other skin problems?</td>
<td></td>
</tr>
<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
<td></td>
</tr>
<tr>
<td>10. Do you have a visual impairment?</td>
<td></td>
</tr>
<tr>
<td>11. Do you use any special devices for bowel or bladder function?</td>
<td></td>
</tr>
<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
<td></td>
</tr>
<tr>
<td>13. Have you had autonomic dysreflexia?</td>
<td></td>
</tr>
<tr>
<td>14. Have you ever been diagnosed with a heat-related (hypothermia) or cold-related (hypothermia) illness?</td>
<td></td>
</tr>
<tr>
<td>15. Do you have muscle spasticity?</td>
<td></td>
</tr>
<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
<td></td>
</tr>
</tbody>
</table>

Explain "yes" answers here

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please indicate if you have ever had any of the following.</td>
<td></td>
</tr>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
</tr>
<tr>
<td>Enlarged spleen</td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
</tr>
<tr>
<td>Osteopenia or osteoporosis</td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
</tr>
<tr>
<td>Weakness in arms or hands</td>
<td></td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
<td></td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
</tr>
<tr>
<td>Sino biceps</td>
<td></td>
</tr>
<tr>
<td>Latex allergy</td>
<td></td>
</tr>
</tbody>
</table>

Explain "yes" answers here

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

Signature of athlete ______________________________ Signature of parent/guardian ______________________________ Date ______________________________

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PREPARTICIPATION PHYSICAL EVALUATION 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 ever 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

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Sex</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP / ( / )</td>
<td>Pulse</td>
<td>Vision R 20/</td>
<td>Vision L 20/</td>
<td>Corrected</td>
</tr>
</tbody>
</table>

MEDICAL

<table>
<thead>
<tr>
<th>Appearance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marfan phenotype, high arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlexia, myopia, MVP, mitral insufficiency</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eyes/ears/nose/throat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pupil equal</td>
</tr>
<tr>
<td>Hearing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lymph nodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart</td>
</tr>
<tr>
<td>Murmurs (Sustoculation standing, supine, ++- Valsalva)</td>
</tr>
<tr>
<td>Location of point of maximal impulse (PMI)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pulses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial and radial pulses</td>
</tr>
</tbody>
</table>

| Lungs |

| Abdomen |

<table>
<thead>
<tr>
<th>Cardiovascular (mains only)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSV lesions suggestive of MRSA, linea corporis</td>
</tr>
</tbody>
</table>

| Neurologic |

<table>
<thead>
<tr>
<th>MUSCULOSKELETAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
</tr>
<tr>
<td>Back</td>
</tr>
<tr>
<td>Shoulder/arm</td>
</tr>
<tr>
<td>Elbow/Forearm</td>
</tr>
<tr>
<td>Wrist/hand/fingers</td>
</tr>
<tr>
<td>Hip/Thigh</td>
</tr>
<tr>
<td>Knee</td>
</tr>
<tr>
<td>Leg/Ankle</td>
</tr>
<tr>
<td>Foot/Toes</td>
</tr>
<tr>
<td>Functional</td>
</tr>
<tr>
<td>Walks, single leg hop</td>
</tr>
</tbody>
</table>

*Consider EKG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider CT exam if in private setting, having third party present is recommended.

*Consider cognitive evaluation or brain imaging if 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 __________________________

Recommends __________________________

I have examined the above-named student and completed the preparticipation physical examination. 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) __________________________ Date of exam __________________________

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
MEDICATION FORM

HAVE DOCTOR FILL IN REQUIRED SECTIONS. PARENTS SIGN FORM AND RETURN COMPLETED FORM TO THE NURSES OFFICE.

STUDENTS NAME: ___________________________ Grade: ______
DATE OF BIRTH: ___________________________ HOME PHONE: __________

The following medication may be administered to my patient ________________

DIAGNOSIS: ___________________________ MEDICATION: ___________________________

DOSAGE/ROUTE: ___________________________ TIME TO BE GIVEN: ______

SIGNIFICANT SIDE EFFECTS: __________________________________________________________

Tylenol (acetaminophen) 325 mg: ______________________ How many: ____________
How frequently: ______________________ PRN: ______________________

Advil / Motrin (ibuprofen) 200 mg: ______________________ How many: ____________
How frequently: ______________________ PRN: ______________________

Cough drops: ______________________ How many: ____________
Tums: ______________________ How many: ____________
Pepto Bismol: ______________________ How many: ____________
How frequently: ______________________ PRN: ______________________

Medication taken at home YES: ______ NO: ______
Name of Medication: ______________________

MD NAME (print): ______________________ MD SIGNATURE: ______________________

MD STAMP: ______________________

I request for my child, ______________________, to receive medication as designated above. I have been informed that the school district, its agents, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medication to my child. I hereby indemnify and hold harmless the Ramapo Indian Hills Board of Education, its agents, and employees from any and all claims.

DATE: _____________ PARENT SIGNATURE: ______________________