Dear Parents or Guardians:

The following information is provided to you at this time so you may address them during the summer months prior to the start of school in September.

**Physicals**
For the health and safety of all students, a physical examination is required by the State of New Jersey for all incoming 9th graders and transfer students. The enclosed Pre-Participation Physical Form is to be used by all students and is to be completed signed and stamped by your child’s physician. Please make sure that the entire physical form is completed and signed in all areas required by law.

Please return this form to the Nurse’s Office PRIOR to the first day of school. The Main Office is open during the Summer for your convenience and a box for the Nurses’ Office will be available. In addition, please include along with your child’s physical any Allergy Action Plan, Epipen Plan, Diabetic Treatment Plan, or Seizure Plan that is required.

**All Pre-Participation Forms for Fall Sports are Due by JULY 18th to the Fall Coaches at Ramapo. All Coaches have an assigned mailbox in the Athletic Director’s Office. Forms should be submitted in a sealed envelope to the Coach, labeled with the athlete’s name, grade and sport.**

**Immunization Requirements**
Please be sure to submit your child’s updated immunization record in its entirety to the school nurse. Your child must be in compliance with the New Jersey State Sanitary Code, Immunizations of Pupils in Schools, in order to remain in school. Failure to comply with the State’s immunization
requirements will prevent your child from attending school. Any time your child receives a new vaccine, please send documentation to the Nurse’s Office.

**Medication In School: Required Medication Consent Form**
Parents and Guardians are encouraged to administer all medications at home whenever possible. However, at times we understand this may not be possible.

All medications required in school require the medication consent form, included in this packet, to be filled out by both the parent/guardian and child’s physician. All medications brought in from home must be dispensed by the school nurse and must be in the original pharmacy container properly labeled by law. Any omission on the medication consent form (missing physician or parent signatures will prevent the nurse from dispensing medication to your child)

We would encourage parents to complete and submit the medication consent form annually (must be submitted each year) to provide for the comfort of your child during the school year.

Generally students do visit the Nurse’s Office and request OTC pain relievers, etc. which do require the medication consent form by law.

All Forms are available online at [RIH.org](http://RIH.org) under Health Services. This includes all action plans for allergies, asthma, diabetes, and seizures.

Enjoy the Summer and we will see you in September!! Welcome to Ramapo High School and we look forward to a great school year!

Kimberly Sikora RN, CSN
Tereena Elias RN, CSN

Certified School Nurses
Ramapo High School
201-891-1500 option #3
ramnurse@rih.org
HEALTH HISTORY UPDATE QUESTIONNAIRE

Student

Date of Last Physical Examination

Age

Grade

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____
   If yes, name of medication(s)

________________________ 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 copy of this form in the chart.)

Date of exam
Name
Sex
Age
Grade
School
Sport(s)
Date of birth

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?
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
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 beat fast 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
   Others:
9. Has a doctor ever ordered a test for your heart? (for example, ECG/EKG, echocardiogram)
10. Do you get light headed 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
13. Has any family member or relative died from heart disease 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
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 splint?
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 wear 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 lock red?
25. Do you have any history of juvenile arthritis or connective tissue disease?
# Preparticipation Physical Evaluation

## THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

**Date of Exam**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. **Do you regularly use a brace, assistive device, or prosthesis?**
7. **Do you use any special brace or assistive device for sports?**
8. **Do you have any rheumatoid arthritis, gout, or any other skin problem?**
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 any seizures or convulsions?**
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:

<table>
<thead>
<tr>
<th>Atlantoaxial Instability</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enteral feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enlarged spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis or osteopenia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbering or tingling in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbering or tingling in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spina bifida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex allergy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explain "yes" answers here

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

<table>
<thead>
<tr>
<th>Signature of athlete</th>
<th>Signature of parent/guardian</th>
<th>Date</th>
</tr>
</thead>
</table>
1. **Physician Reminders**

- 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 any medication 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>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>(      )</td>
<td>(    )</td>
<td>(      )</td>
</tr>
</tbody>
</table>

**Medical**

- Appearance:
  - Must be signed by physician, including height, weight, and other pertinent data.

- Eyes/ears/nose/throat:
  - Pupils equal
  - Hearing

- Lymph nodes

- Heart:
  - Murmurs (assessing standing, supine, 4/6 value)
  - Location of point of maximal impulse (PMI)

- Pulses:
  - Simultaneous femoral and radial pulses

- Lungs

- Abdomen

- Gastrointestinal (males only)

- Skin
  - HIV test positive, suggestive of MSA, liver corpus

- Neurologic

**Musculoskeletal**

- Neck
- Back
- Shoulder/arm
- Elbow/forearm
- Wrist/hand/fingers
- Hip/thigh
- Knee
- Leg/leg
- Foot/toes
- Functional
  - Walk, single leg hop

*Consider EKG, echocardiogram, and refer to cardiologist for abnormal cardiac history or exam.
*Consider G6PD test if in private setting, having third party present is recommended.
*Consider exquisite evaluation or baseline neuropsych evaluation 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

Recommendations: [Signature of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)]

Date of exam: [Date]

Address: [Address]

Phone: [Phone]

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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 (325 mg): ____________________________ How many: __________
How frequently: ____________________________ PRN: __________

Advil 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: ____________________________