Dear Parent/Guardian:

THIS LETTER IS REGARDING YOUR CHILD’S INTEREST IN PARTICIPATING IN ATHLETICS.

THE PACKET INFORMATION HAS CHANGED. PLEASE READ IT CAREFULLY.

We are writing in regard to the state requirements for students to participate in athletics for Pleasantville Public Schools. As required by State of New Jersey code (N.J.A.C. 6A:16-2.2[b]), students who wish to participate in interscholastic sports must receive a medical examination & clearance by a medical doctor. If a student does not have medical insurance, the school’s athletic physician is required to provide this examination at his/her office or other appropriately equipped facility. The medical examination (N.J.A.C. 6A:16-2.2[h]), must include a determination concerning the student’s participation. In addition, as required by State of New Jersey code (P.L. 2010, c.94, P.L. 2013, c.71 & Executive Order 72) parents & students must receive, review & sign the Concussion & Sudden Cardiac Awareness Sheets.

STEP 1 – FOR ALL ATHLETES
A. You, as parent/guardian, are to keep the first two pages of this packet as a reference; this includes the Concussion Awareness Sheet and the Sudden Cardiac Death Sheet.
B. You and your child must complete & sign the following forms: Permission Slip, Parent Awareness Sheet & the Preparticipation Physical Evaluation HISTORY FORM(s).

STEP 2 – FOR ATHLETES WITH INSURANCE
A. Please make an appointment with your child’s doctor for a physical. The doctor must review the Preparticipation Physical Evaluation HISTORY FORMS(s) and must complete & sign the Preparticipation Physical Evaluation PHYSICAL EXAMINATION FORMS.
B. After the physical, all forms must be given to the Athletic Director (including Permission Slip and Parent Awareness Sheet) by the due date announced in school.

STEP 2 - OR ATHLETES WITHOUT MEDICAL INSURANCE
A. Entire completed packet must be given to the coach by the due date announced in school.
B. The Athletic Trainer will schedule the athlete for a physical with the school’s physician pending academic eligibility. These physicals will be arranged in advance and will be held during the preseason of the upcoming sport season.

NOTE: Your child will not be able to start official practice until all paperwork & physical are completed and returned.

If you have any questions or need further information, please feel free to contact the Athletic Trainer at 609-383-6900 Ext. 4042 or the Athletic Director at 609-383-6900 Ext. 4043. Thank you for your time.

Sincerely,

Derrick L. Carrington, Sr.
Athletic Director

Kristen Sinclair, ATC
Athletic Trainer
Sports-Related Concussion and Head Injury Fact Sheet and Parent/Guardian Acknowledgement Form

A concussion is a brain injury that can be caused by a blow to the head or body that disrupts normal functioning of the brain. Concussions are a type of Traumatic Brain Injury (TBI), which can range from mild to severe and can disrupt the way the brain normally functions. Concussions can cause significant and sustained neuropsychological impairment affecting problem solving, planning, memory, attention, concentration, and behavior.

The Centers for Disease Control and Prevention estimates that 300,000 concussions are sustained during sports related activities nationwide, and more than 62,000 concussions are sustained each year in high school contact sports. Second-impact syndrome occurs when a person sustains a second concussion while still experiencing symptoms of a previous concussion. It can lead to severe impairment and even death of the victim.

Legislation (P.L. 2010, Chapter 94) signed on December 7, 2010, mandated measures to be taken in order to ensure the safety of K-12 student-athletes involved in interscholastic sports in New Jersey. It is imperative that athletes, coaches, and parent/guardians are educated about the nature and treatment of sports related concussions and other head injuries. The legislation states that:

- All Coaches, Athletic Trainers, School Nurses, and School/Team Physicians shall complete an Interscholastic Head Injury Safety Training Program by the 2011-2012 school year.
- All school districts, charter, and non-public schools that participate in interscholastic sports will distribute annually this educational fact to all student athletes and obtain a signed acknowledgement from each parent/guardian and student-athlete.
- Each school district, charter, and non-public school shall develop a written policy describing the prevention and treatment of sports-related concussion and other head injuries sustained by interscholastic student-athletes.
- Any student-athlete who participates in an interscholastic sports program and is suspected of sustaining a concussion will be immediately removed from competition or practice. The student-athlete will not be allowed to return to competition or practice until he/she has written clearance from a physician trained in concussion treatment and has completed his/her district’s graduated return-to-play protocol.

Quick Facts
- Most concussions do not involve loss of consciousness
- You can sustain a concussion even if you do not hit your head
- A blow elsewhere on the body can transmit an “impulsive” force to the brain and cause a concussion

Signs of Concussions (Observed by Coach, Athletic Trainer, Parent/Guardian)
- Appears dazed or stunned
- Forgets plays or demonstrates short term memory difficulties (e.g. unsure of game, opponent)
- Exhibits difficulties with balance, coordination, concentration, and attention
- Answers questions slowly or inaccurately
- Demonstrates behavior or personality changes
- Is unable to recall events prior to or after the hit or fall

Symptoms of Concussion (Reported by Student-Athlete)
- Headache
- Nausea/vomiting
- Balance problems or dizziness
- Double vision or changes in vision
- Sensitivity to light/sound
- Feeling of sluggishness or fogginess
- Difficulty with concentration, short term memory, and/or confusion

What Should a Student-Athlete do if they think they have a concussion?
- Don’t hide it. Tell your Athletic Trainer, Coach, School Nurse, or Parent/Guardian.
- Report it. Don’t return to competition or practice with symptoms of a concussion or head injury. The sooner you report it, the sooner you may return-to-play.
- Take time to recover. If you have a concussion your brain needs time to heal. While your brain is healing you are much more likely to sustain a second concussion. Repeat concussions can cause permanent brain injury.
What can happen if a student-athlete continues to play with a concussion or returns to play too soon?

- Continuing to play with the signs and symptoms of a concussion leaves the student-athlete vulnerable to second impact syndrome.
- Second impact syndrome is when a student-athlete sustains a second concussion while still having symptoms from a previous concussion or head injury.
- Second impact syndrome can lead to severe impairment and even death in extreme cases.

Should there be any temporary academic accommodations made for Student-Athletes who have suffered a concussion?

- To recover cognitive rest is just as important as physical rest. Reading, texting, testing—even watching movies can slow down a student-athletes recovery.
- Stay home from school with minimal mental and social stimulation until all symptoms have resolved.
- Students may need to take rest breaks, spend fewer hours at school, and be given extra time to complete assignments, as well as being offered other instructional strategies and classroom accommodations.

Student-Athletes who have sustained a concussion should complete a graduated return-to-play before they may resume competition or practice, according to the following protocol:

- Step 1: Completion of a full day of normal cognitive activities (school day, studying for tests, watching practice, interacting with peers) without reemergence of any signs or symptoms. If no return of symptoms, next day advance.
- Step 2: Light Aerobic exercise, which includes walking, swimming, and stationary cycling, keeping the intensity below 70% maximum heart rate. No resistance training. The objective of this step is increased heart rate.
- Step 3: Sport-specific exercise including skating, and/or running: no head impact activities. The objective of this step is to add movement.
- Step 4: Non-contact training drills (e.g. passing drills). Student-athlete may initiate resistance training.
- Step 5: Following medical clearance (consultation between school health care personnel and student-athlete’s physician), participation in normal training activities. The objective of this step is to restore confidence and assess functional skills by coaching and medical staff.
- Step 6: Return to play involving normal exertion or game activity.

For further information on Sports-Related Concussions and other Head Injuries, please visit:
www.cdc.gov/concussion/sports/index.html www.nfhs.com

PLEASE DO NOT RETURN THIS FORM WITH THE PHYSICAL PACKET.
IT IS FOR YOU TO KEEP AS REFERENCE MATERIAL.
Sudden Cardiac Death in Young Athletes

Sudden death in young athletes between the ages of 10 and 19 is very rare. What, if anything, can be done to prevent this kind of tragedy?

What is sudden cardiac death in the young athlete?

Sudden cardiac death is the result of an unexpected failure of proper heart function, usually (about 60% of the time) during or immediately after exercise without trauma. Since the heart stops pumping adequately, the athlete quickly collapses, loses consciousness, and ultimately dies unless normal heart rhythm is restored using an automated external defibrillator (AED).

How common is sudden death in young athletes?

Sudden cardiac death in young athletes is very rare. About 100 such deaths are reported in the United States per year. The chance of sudden death occurring to any individual high school athlete is about one in 200,000 per year.

Sudden cardiac death is more common in males than in females; in football and basketball than in other sports; and in African-Americans than in other races and ethnic groups.

What are the most common causes?

Research suggests that the main cause is a loss of proper heart rhythm, causing the heart to quiver instead of pumping blood to the brain and body. This is called ventricular fibrillation (VEN-TRICK-yoo-far ribb-roo-LAY-shun). The problem is usually caused by one of several cardiovascular abnormalities and electrical diseases of the heart that go unnoticed in healthy-appearing athletes.

The most common cause of sudden death in an athlete is hypertrophic cardiomyopathy (hi-per-TRO-fic CAR-dee-oh-my-OP-a-thee) also called HCM. HCM is a disease of the heart, with abnormal thickening of the heart muscle, which can cause serious heart rhythm problems and blockages to blood flow. This genetic disease runs in families and usually develops gradually over many years.

The second most likely cause is congenital (kon-JEN-ital) (i.e., present from birth) abnormalities of the coronary arteries. This means that these blood vessels are connected to the main blood vessel of the heart in an abnormal way. This differs from blockages that may occur when people get older (commonly called “coronary artery disease,” which may lead to a heart attack).

Other diseases of the heart that can lead to sudden death in young people include:

- Myocarditis (my-oh-car-DIE-tis), an acute inflammation of the heart muscle (usually due to a virus).
• Dilated cardiomyopathy, an enlargement of the heart for unknown reasons.
• Long QT syndrome and other electrical abnormalities of the heart which cause abnormal fast heart rhythms that can also run in families.
• Marfan syndrome, an inherited disorder that affects heart valves, walls of major arteries, eyes and the skeleton. It is generally seen in unusually tall athletes, especially if being tall is not common in other family members.

Are there warning signs to watch for?
In more than a third of these sudden cardiac deaths, there were warning signs that were not reported or taken seriously. Warning signs are:
• Fainting, a seizure or convulsions during physical activity
• Fainting or a seizure from emotional excitement, emotional distress or being startled
• Dizziness or lightheadedness, especially during exertion
• Chest pains, at rest or during exertion
• Palpitations - awareness of the heart beating unusually (skipping, irregular or extra beats) during athletics or during cool down periods after athletic participation
• Fatigue or tiring more quickly than peers
• Being unable to keep up with friends due to shortness of breath

What are the current recommendations for screening young athletes?
New Jersey requires all school athletes to be examined by their primary care physician (“medical home”) or school physician at least once per year. The New Jersey Department of Education requires use of the specific Annual Athletic Pre-Participation Physical Examination Form.
This process begins with the parents and student-athletes answering questions about symptoms during exercise (such as chest pain, dizziness, fainting, palpitations or shortness of breath) and questions about family health history.
The primary healthcare provider needs to know if any family member died suddenly during physical activity or during a seizure. They also need to know if anyone in the family under the age of 50 had an unexplained sudden death such as drowning or car accidents. This information must be provided annually for each exam because it is so essential to identify those at risk for sudden cardiac death.
The required physical exam includes measurement of blood pressure and a careful listening examination of the heart, especially for murmurs and rhythm abnormalities. If there are no warning signs reported on the health history and no abnormalities discovered on exam, no further evaluation or testing is recommended.

When should a student athlete see a heart specialist?
If the primary healthcare provider or school physician has concerns, a referral to a child heart specialist, a pediatric cardiologist, is recommended. This specialist will perform a more thorough evaluation, including an electrocardiogram (ECG), which is a graph of the electrical activity of the heart. An echocardiogram, which is an ultrasound test to allow for direct visualization of the heart structure, will likely also be done. The specialist may also order a treadmill exercise test and a monitor to enable a longer recording of the heart rhythm. None of the testing is invasive or uncomfortable.

Can sudden cardiac death be prevented just through proper screening?
A proper evaluation should find most, but not all, conditions that would cause sudden death in the athlete. This is because some diseases are difficult to uncover and may only develop later in life. Others can develop following a normal screening evaluation, such as an infection of the heart muscle from a virus.
This is why screening evaluations and a review of the family health history need to be performed on a yearly basis by the athlete’s primary healthcare provider. With proper screening and evaluation, most cases can be identified and prevented.

Why have an AED on site during sporting events?
The only effective treatment for ventricular fibrillation is immediate use of an automated external defibrillator (AED). An AED can restore the heart back into a normal rhythm. An AED is also life-saving for ventricular fibrillation caused by a blow to the chest over the heart (commotio cordis).
The American Academy of Pediatrics/New Jersey Chapter recommends that schools:
• Have an AED available at every sports event (three minutes total time to reach and return with the AED)
• Have personnel available who are trained in AED use present at practices and games.
• Have coaches and athletic trainers trained in basic life support techniques (CPR)
• Call 911 immediately while someone is retrieving the AED.
PLEASANTVILLE SCHOOL DISTRICT
MIDDLE SCHOOL – ATHLETIC DEPARTMENT
PLEASANTVILLE, NEW JERSEY 08232

NAME:____________________________ PHONE:_____________________________

ADDRESS:_________________________________________________________________

____________________________ _______________________

PARENT/GUARDIAN: ________________________________________________________

____________________________ _______________________

CELL #:________________________________ CELLS #:___________________________

DATE OF BIRTH: ______/_____/______ AGE: _______ GRADE: ______ TEACHER________

(Month/Day/Year)

SEX: M _______ / F _______ HOMEROOM #: _______________________

I hereby apply for the privilege of trying out for the ____________________________________________

(sport) ___________ team in ________________

(year)

In order to represent the Middle School of Pleasantville in interscholastic athletics, the following standards and rules must be adhered to:

1. Adherence to the basic standard of A.C.C.L regarding age, residence, years of competition. Adherence to Pleasantville’s standards regarding academics and good disciplinary standing.

2. Every athlete is required to pass a strict physical examination prior to competing in interscholastic athletics each year and complete a health history update after the initial physical examination.

3. Every athlete is completely responsible for all equipment issued. If equipment is not turned in when requested by the coach, the athlete will be held monetarily responsible.

4. Any athlete found with drugs or alcohol in his/her possession or found using same, will be severely dealt with.

5. Students must maintain good disciplinary standing to participate in any athletic activity. A student is not eligible to participate in practice or competition while serving a detention or suspension (in-school or out-of-school).

6. Every athlete must realize that he/she is representing Pleasantville High School and make it a point to govern himself/herself in a manner that their connection with the sport will bring honor to it and the school.

I HAVE READ THE STANDARDS AND RULES AND UNDERSTAND THAT VIOLATIONS OF SAID RULES AND STANDARDS MAY RESULT IN SUSPENSION OR EXCLUSION FROM PARTICIPATION IN ATHLETICS.

____________________________

STUDENT SIGNATURE

____________________________

DATE

PARENT/GUARDIAN CONSENT

I give my permission for ___________________________________________ to participate in organized district-sponsored athletics, realizing that such activity involves the potential for injury which is inherent in all sports. I acknowledge that even with the best coaching, use of 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 acknowledge that I have read and understand this warning.

I furthermore, release the said school from all liability for injuries received by my child while enroute to or from contests which are held at other schools.

____________________________

PARENT/GUARDIAN SIGNATURE

____________________________

DATE
PERMISSION TO EXTEND EMERGENCY MEDICAL CARE IN THE ABSENCE OF A PARENT OR GUARDIAN

In the absence of myself as parent/guardian, I hereby give any recognized hospital or medical facility permission to extend treatment to my son/daughter, ________________, if he/she should be injured while participating in district-sponsored athletics.

I understand that my child’s school insurance is a secondary insurance coverage plan and it is therefore necessary to supply the following insurance information in order to process an insurance claim for payment of services rendered by said recognized hospital or medical facility.

________________________________________________________________________________________

DATE

________________________________________________________________________________________

PARENT/GUARDIAN SIGNATURE

Please list any and all medical issues, allergies and medications your child has (asthma, sickle cell trait, etc.):

________________________________________________________________________________________

________________________________________________________________________________________

EMERGENCY CONTACT PERSON

NAME: ___________________________ RELATIONSHIP: ___________________________

Home: ___________________________ Work: ___________________________ Cell: ___________________________

INSURANCE COVERAGE INFORMATION

NAME OF COMPANY ___________________________

SUBSCRIBER ___________________________

COMPANY STREET ADDRESS ___________________________

CITY ___________________________ STATE ___________________________ ZIP CODE ___________________________

TELEPHONE NUMBER ___________________________

ID NUMBER ___________________________ GROUP NUMBER ___________________________

☐ MY CHILD IS NOT COVERED BY ANY HEALTH INSURANCE. (Please Check if Applicable)
Dear Parent or Guardian:

The last two pages of the athletic medical update packet includes a *Sport-Related Concussion & Head Injury Fact Sheet*, and a *Sudden Cardiac Death in Young Athletes Fact Sheet*. Pursuant to Legislation signed on December 10, 2010 (P.L.2010, Chapter 94) & June 27, 2013 (P.L.2013, c.71), we as a school district are responsible to provide you with these facts sheets. Please keep the last two forms for your information. In addition we are required to receive written certification from parents & students that they received & reviewed the information.

Therefore, by signing below you acknowledge that you have received and reviewed the above mentioned forms with your child.

<table>
<thead>
<tr>
<th>Student-Athlete’s Signature</th>
<th>Print Student-Athlete’s Name</th>
<th>Date</th>
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<th>Parent-Guardian’s Signature</th>
<th>Print Parent-Guardian’s Name</th>
<th>Date</th>
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This form should be returned with the medical update form to your child’s coach.
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: ___________________________ Date of birth: ___________________________

Name: ___________________________ School: ___________________________

Sex: __________________ Grade: ___________ 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 [ ] Arthritis [ ] Diabetes [ ] Infections [ ] Other: ___________________________

3. Have you ever spent the night in a 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
   [ ] Arrhythmia or heart rhythm disorder [ ] Other: ___________________________

9. Has a doctor ever ordered a test for your heart? (For example: EKG, echocardiogram) [ ] Yes [ ] No

10. Do you get light-headed or feel short of breath more 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? [ ] Yes [ ] No

14. Does anyone in your family have hyperlipidemia (high cholesterol), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long 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 a broken or fractured bone or dislocated joint? [ ] Yes [ ] No

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, 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 have had an x-ray for neck instability or atlantoaxial instability (bony syndrome or dislocation)? [ ] Yes [ ] No

22. Do you regularly use a brace, orthotic, 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. Have you been born without or are you missing a kidney, an eye, a testicle (or testicles), your spleen, or any other organ? [ ] Yes [ ] No

30. Do you have a history of a genetic disorder? [ ] Yes [ ] No

31. Have you had infections mononucleosis, mumps, or whooping cough? [ ] 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 a 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? [ ] Yes [ ] No

54. How many periods have you had in the last 12 months? [ ] Yes [ ] No

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

Signature of athlete: ___________________________ Date: ___________________________

Signature of parent/guardian: ___________________________ Date: ___________________________

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

**The Athlete with Special Needs: Supplemental History Form**

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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

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<th>Yes</th>
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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 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 urinations that cannot be controlled by medication?

Explain "yes" answers here

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Please indicate if you have ever had any of the following.

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<th>X-ray evaluation for structural instability</th>
<th>Reduplicated joints (more than one)</th>
<th>Easy bleeding</th>
<th>Enlarged spleen</th>
<th>Hepatitis</th>
<th>Osteopenia or osteoporosis</th>
<th>Difficulty controlling bowel</th>
<th>Difficulty controlling bladder</th>
<th>Numbness or tingling in arms or hands</th>
<th>Numbness or tingling in legs or feet</th>
<th>Weakness in arms or hands</th>
<th>Weakness in legs or feet</th>
<th>Recent change in coordination</th>
<th>Recent change in ability to walk</th>
<th>Spina bifida</th>
<th>Latex allergy</th>
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Explain "yes" answers here

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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 guardian | Date |
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New Jersey Department of Education 2014. Pursuant to P.L. 2013, c. 71
# 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 used marijuana, cocaine, heroin, or any other drug?
   * Have you used alcohol or any other drug or drug replacement therapy in the past month?
   * Have you ever had major surgery or any other medical condition that might affect your athletic performance?
   * Have you ever taken any medications to help you gain or lose weight or improve your performance?
   * Do you need any special accommodations?

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

### Examination

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<tr>
<th>Height</th>
<th>Weight</th>
<th>M</th>
<th>F</th>
<th>Pulse</th>
<th>Vision R 20/</th>
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### Medical

#### Appearance
- Marfan syndrome
- Hypertension
- Cardiovascular disease
- Atherosclerotic disease
- Congenital heart disease
- Pulmonary disease
- Thyroid disease
- Other disease

#### Eyes/ears/throat
- Visual acuity
- Hearing
- Nasal congestion
- Other otolaryngologic

#### Heart
- Murmurs
- Arrhythmias
- Other cardiac disease

#### Pupils
- Symmetric
- Reaction
- Other ocular disease

#### Lungs
- Respiratory disease
- OTHER

#### Abdomen
- Stomach/Gastrointestinal
- Liver
- Kidneys
- Other abdominal disease

#### Neurologic
- Strength
- Coordination
- Reflexes
- Sensory
- Other neurological

#### Musculoskeletal

- Neck
- Back
- Shoulder/arm
- Elbow/wrist
- Hip/leg
- Knee
- Leg/ankle
- Feet/legs
- Function
- Other musculoskeletal

#### Other

- Not cleared
  - Pending further evaluation
  - For any sports
  - For certain sports

### 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. It 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: ____________________________

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 ____________________________

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
To the Examining Healthcare Provider:

In order to insure that the medical records of our student-athletes are current and complete, can you please provide the Pleasantville School District with the following information. Thank you for your cooperation and assistance.

Most recent immunizations and dates administered (or attach documentation):

Medications currently prescribed, with dose and frequency:

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<th>Medication Name</th>
<th>Dosage</th>
<th>Frequency</th>
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Additional observations:

General Diagnosis:

General Recommendations:

HISTORY REVIEWED AND STUDENT EXAMINED BY:

Physician/Provider's Stamp:

Primary Care Provider
School Physician Provider
License Type:
- MD/DO
- APN
- PA

Physician/Provider's Signature:

Today's Date: ______________

DATE OF EXAM: ______________
NOTE: 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.

History and Physical Reviewed By: __________________________ Date: ______________

Title of Reviewer (please check one): ☐ School Nurse ☐ School Physician

Medical Eligibility Notification Sent to Parent/Guardian by School Physician ______________

☐ Letter of notification is attached.

OR

Parent notification indicates that:

☐ Participation Approved without limitations.

☐ Participation Approved with limitations pending evaluation.

☐ Participation NOT Approved

Reason(s) for Disapproval: ________________________________________________