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 _____

Date of Exam _____

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

Date of Exam _____

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

PARAMUS PUBLIC SCHOOLS
PARAMUS, NEW JERSEY 07652

Margaret Damiano, M.Ed, Supervisor
STUDENT PERSONNEL SERVICES
145 Spring Valley Road
(201)-261-7800 – Ext. 3020
mdamiano@paramus.k12.nj.us

May, 2014

Dear Parents/Guardians

The New Jersey Department of Health and Senior Services has mandated that children born after January 1, 1997 and enrolled in Grade Six and above or students transferring into a New Jersey school from another state or country will be required to receive a booster dose of the diphtheria, tetanus and pertussis vaccine as well as one dose of the meningococcal vaccine.

1. Tdap (Tetanus, diphtheria, acellular pertussis)
   Tdap must be given no earlier than the 10th birthday
   If a child has received a Td booster dose less than five years ago, he/she will not be required to receive a Tdap dose until five years have elapsed from the last DTP/DtaP or Td dose.
2. Meningococcal vaccine

Students must provide documentation of these two immunizations from their primary care provider. All pupils are to be in compliance with the New Jersey immunization regulations in order to remain in school.
Please have your Primary Health Care Provider complete the form below, detach and return to the school nurse. If you have any questions or concerns regarding this notice, please call me at 201-261-7800 ext. 3020. Thank you in advance for your cooperation in this matter.

Sincerely,

Margaret Damiano, M.Ed.
Supervisor, Student Personnel Services

CC: Ms. Carla Alvarez, Principal & Ms. Nancy Fox (x8222), Nurse
Mr. Thomas LoBue, Principal & Mrs. Christine Ilenko (x8126), Nurse
Mr. Anthony Panico, Principal & Mrs. Lisa Lotterman (x3056), Nurse

- -

Student_____ Date of Birth_____

The above named student has received:
1. Tetanus, diphtheria and acellular pertussis (Tdap) booster _____
   Month/day/year
2. Meningococcal vaccine on _____
   Month/day/year

Primary Health Care Provider Signature: _____Date_____

Stamp of Primary Health Care Provider_____
(Name /Address/Phone)

HEALTH QUESTIONNAIRE
PARAMUS PUBLIC SCHOOLS

PARENTS/GUARDIANS: PLEASE COMPLETE **BOTH SIDES** OF THIS HEALTH FORM

Child's Name:_____ Birth Date:_____Sex: _____

Parents/Guardians:_____Siblings:

Age: / / /

Sex: / / /

School:_____Grade:_____

No.	Question	Y	N	Number & Explain All "YES" Answers
1.	Were there any problems during pregnancy and/or birth?			
2.	Do you have any concerns about your child's health (eating, sleeping, teeth, weight, skin, etc.)?			
3.	Has your child ever had any eye problems (difficulty seeing, crossed eyes, squinting, frequently red, watery)?			
4.	Has your child ever had an eye exam? Date: _____ Result:			
5.	Does your child wear glasses? All day?			
6.	Has your child ever had any ear or hearing problems (frequent earaches, difficulty hearing, tubes in ears)?			
7.	Has your child ever had a hearing test? Date: _____ Has your child ever had a hearing evaluation? Date: _____ Results:			
8.	Does your child wear hearing aids?			
9.	Did your child have any delays in motor skills?			
10.	Does your child have any speech problems (difficult to understand, stuttering, slow speech development)?			
11.	Has your child ever had speech therapy? Date:			
12.	Does your child have any other physical problem or impairment which might affect normal academic progress or participation in the usual school program?			
13.	Should there be any restriction of physical activity in school? Include nature and duration of restriction.			
14.	Does your child have any psychological, emotional or behavioral problems that might affect school performance?			
15.	Has your child had any accidents or illnesses serious enough to require hospitalization?			
16.	Has your child had any broken bones?			
17.	Is your child on any daily or long term medication?			
18.	Does your child have any health problem that might require emergency action while he/she is at school (seizures, insect sting allergy, bleeding problem, diabetes, severe asthma, etc.)?			
19.	Is there a family history of chronic illness or learning problems?			

HEALTH HISTORY FORM
PARAMUS PUBLIC SCHOOLS

PARENTS/GUARDIANS: PLEASE COMPLETE **BOTH SIDES** OF THIS HEALTH FORM

Child's Name:_____Grade:_____

Condition	Y	N	Date	Explanation
Asthma				
Allergic to Drugs				
Allergies – food, environment				
Chicken Pox				
Seizure Disorder				
Diabetes				
Ear Infections				
Hearing Problems				
Emotional Problems				
Heart Disease				
Hepatitis				
Kidney Disease				
Mononucleosis				
Nosebleeds				
Pneumonia				
Scarlet Fever				
Strep Infection				
Speech Difficulties				
Concussions				
Fractures				
Operations				
Severe Injuries				
Other Hospitalizations				
Other Conditions				
Other Injuries				

Is your child currently taking medication? _____ Name of Medication(s):_____

If yes, for what condition(s): _____

I give my permission for the school nurse to share all health information with the faculty as needed.

Signature of Parent/Guardian: _____ Date: _____

Nurse's Summary: _____

_____

Student: _____ Birthdate: _____

IMMUNIZATION RECORD

Vaccine	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year
DPT/Td*					
Tdap****					
Polio*					
MMR(measles/mumps/rubella)					
Measles**					
Mumps**					
Rubella**					
HIB***					
Hepatitis B (*)					
Varivax [**]					
Meningococcal******					

Mantoux**** **Date administered _____ Date read _____**

Results:

☐ **Negative**

☐ **Positive** **Induration _____mm**

Chest X-Ray: Date _____ **Results _____**

Medication _____ Date started _____ Date finished _____

(specify)

Physician Name/Address (Please Stamp): **Date _____**

_____

Physician's signature _____ Phone _____

***Students less than 7 years of age must have one dose of DPT and Polio on/after fourth birthday. Alternately, a total of 5 doses of DPT and any 4 doses of appropriately spaced polio are acceptable.**

****Students born on/after 1/1/90 must have second dose of measles containing vaccine or documentation of measles immunity. The first measles vaccine must be administered no earlier than the 1st birthday.**

*****A minimum of one dose HIB vaccine [after 1st birthday] is required for those entering preschool (ECC).**

(*) Students born on/after 1/1/90, entering, attending, or transferring into a New Jersey school on or after 9/1/2001, shall have received 3 doses of Hepatitis B vaccine. Students between 11-15 year of age may receive 2 doses of Recombivax HB of Hep B Adult Formulation vaccine.

[**] All students born after 1/1/90 who attend or transfer into a NJ school from another state or country is required to have one dose of varicella [administered no earlier than the 1st birthday] or proof of varicella immunity.

******Students born on or after 1/1/97, and entering or attending Grade 6 are required to receive one dose of Tdap given no earlier than the 10th birthday as long as 5 years have elapsed from the last DTP/DTaP or Td dose and one dose of a Meningococcal vaccine after they turn 11 years of age. Students born on or after 1/1/97, and transferring into a New Jersey school from another state or country, shall receive one dose of Tdap, provided at least 5 years have elapsed from the last documented Td dose and one dose of Meningococcal vaccine.**
******* Mantoux administered is required per N.J. Department of Health and Senior Services.**

Rev. 6/2011