

# HAWORTH SCHOOL DISTRICT



Phone (201) 384-5526 ♦ Fax (201) 384-8619  
205 Valley Road ♦ Haworth, NJ 07641 ♦ [www.haworth.org](http://www.haworth.org)

## PHYSICIAN and PARENT INSTRUCTIONS: COMPLETING ATHLETIC MEDICAL FORMS

**Do not leave any blank areas** or the forms will be returned, which may delay or prevent your child from being able to try out. The law prohibits school nurses from completing any missing parts of the exam including vision testing numbers and pulse.

If your child wears glasses or contact lenses and cannot have their vision screening done at their physician's office, you must provide an **up-to-date vision clearance (exam must be within 365 days)** from their eye doctor, **which must include visual acuity**.

### 1. ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION Form.

This form has two parts (PART A and B) which **must** be submitted together.

#### Part A: HEALTH HISTORY QUESTIONNAIRE

To be completed by **PARENT** and submitted with Part B.  
Must be reviewed by your examining physician.

#### Part B: PHYSICAL EVALUATION form

To be completed by your **PHYSICIAN** and is valid for 365 days from the *date* of the examination.  
Your physician **must review Part A**.

### 2. HEALTH UPDATE Form

If your child's medical examination was completed **more than 60 days prior to the sport's first practice date** then a parent must additionally complete, a 'Health Update Form.' **Changes in health status** may require a note from your physician stating, "Cleared for Sports."

#### DEADLINES DATES FOR SPORTS FORM SUBMISSION

<u>SPORT SEASON</u>		<u>2011-2012</u>
FALL	Soccer, Volleyball	Sept. 13, 2011
WINTER	Basketball	Nov. 1, 2011
SPRING	Track	March 1, 2012

Health sports forms are available at Haworth Public School Health Office and may be downloaded at [www.haworth.org](http://www.haworth.org) (select school nurse then health forms then Sports Forms for Download).

Fax Policy: The school will not fax forms to doctor's offices. Incoming faxes are discouraged but can be temporarily accepted before deadlines, and the signed original form must follow within seven (7) days.

If you have any questions, contact the school nurse, Mrs. Nancy Wise at 201-384-5526 ext. 5. or email [wise@nvnet.org](mailto:wise@nvnet.org)

### Self-Check List

Pre-Participation Physical Forms Part A & B  
Parent Permission Form  
Health History Update Form

\_\_\_\_\_ Yes  
\_\_\_\_\_ Yes  
\_\_\_\_\_ Yes

# Parent

## PARENTS PERMISSION FORM FOR ATHLETIC PARTICIPANTS

Name: \_\_\_\_\_ Grade/Homeroom: \_\_\_\_\_

I give consent for my child \_\_\_\_\_ to compete in the following sports during the school year 20\_\_\_\_ to 20\_\_\_\_:

Track    Soccer    Basketball    Volleyball    Wrestling    Floor Hockey

I waive any claim against the Board of Education, its agents, employees or representatives for any damage for injuries said child might sustain while participating in above-mentioned sports. I understand I am liable for any expenses incurred for injuries connected with participation in sports, which are not covered by any insurance policy, which is in force at the time of injury. I give permission for first aid to be rendered in case of accident to my child and also for immediate hospitalization if necessary for emergency treatment at the nearest available hospital.

Name of family physician to be notified: Dr. \_\_\_\_\_ Phone: \_\_\_\_\_

PARENTS SIGNATURE: \_\_\_\_\_

School insurance is required unless the student elects (by signed parental statement) not to participate in the insurance coverage. All insured student participants will be required to pay the cost of the premium.

Student insurance desired: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent signature required)

Student insurance NOT desired: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent signature required)

(Sports permission slips 7-10)

**New Jersey Department of Education      Parent**  
**ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM**

**Part A: HEALTH HISTORY QUESTIONNAIRE**-Completed by the parent and student and reviewed by examining provider

**Part B: PHYSICAL EVALUATION FORM**-Completed by examining licensed provider with MD, DO, APN or PA

**Part A: HEALTH HISTORY QUESTIONNAIRE**

Today's Date: \_\_\_\_\_  
 \_\_\_\_\_

Date of Last Sports Physical: \_\_\_\_\_

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Student's Name: \_\_\_\_\_ Sex: M F (circle one) Age: \_\_\_\_ Grade: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ School: \_\_\_\_\_ District: \_\_\_\_\_  
 Sport(s): \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Provider Name (Medical Home): \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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**EMERGENCY CONTACT INFORMATION**

Name of parent/guardian: \_\_\_\_\_ Relationship to student: \_\_\_\_\_  
 Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_  
 Additional emergency contact: \_\_\_\_\_ Relationship to student: \_\_\_\_\_  
 Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

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**Directions:** Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

- 1. Have you ever had, or do you currently have:**
- a. Restriction from sports for a health related problem? Y / N / Don't Know
  - b. An injury or illness since your last exam? Y / N / Don't Know
  - c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know
    - (1.) An inhaler or other prescription medicine to control asthma? Y / N / Don't Know
  - d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know
  - e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
  - f. Any **allergies** to medications? **Y / N / Don't Know**
  - g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't Know
    - (1.) If yes, check type of reaction:
      - Rash    Hives    Breathing or other anaphylactic reaction
      - (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) Y / N / Don't Know
  - h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know
  - i. A blood relative who died before age 50? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**List all medications here:**

Medication Name	Dosage	Frequency



**2. Have you ever had, or do you currently have, any of the following head-related conditions:**

- |   |                    |
|---|--------------------|
| a. Concussion or head injury (including "bell rung" or a "ding")? | Y / N / Don't      |
| Know  |                    |
| b. Memory loss?   | Y / N / Don't Know |
| c. Knocked out?   | Y / N / Don't Know |
| c. A seizure?   | Y / N / Don't Know |
| d. Frequent or severe headaches (With or without exercise)?       | Y / N / Don't Know |
| e. Fuzzy or blurry vision   | Y / N / Don't Know |
| f. Sensitivity to light/noise                                     | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

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**3. Have you ever had, or do you currently have, any of the following heart-related conditions:**

- |  |                    |
|--|--------------------|
| a. Restriction from sports for heart problems?   | Y / N / Don't Know |
| b. Chest pain or discomfort?   | Y / N / Don't Know |
| c. Heart murmur?   | Y / N / Don't Know |
| d. High blood pressure?  | Y / N / Don't Know |
| e. Elevated cholesterol level?   | Y / N / Don't Know |
| f. Heart infection?  | Y / N / Don't Know |
| g. Dizziness or passing out during or after exercise without known cause?                        | Y / N / Don't Know |
| h. Has a provider ever ordered a heart test ( EKG, echocardiogram, stress test, Holter monitor)? | Y / N / Don't Know |
| i. Racing or skipped heartbeats?   | Y / N / Don't Know |
| j. Unexplained difficulty breathing or fatigue during exercise?                                  | Y / N / Don't Know |
| k. Any family member (blood relative):   |                    |
| (1.) Under age 50 with a heart condition?  | Y / N / Don't Know |
| (2.) With Marfan Syndrome?   | Y / N / Don't Know |
| (3.) Died of a heart problem before age 50? If yes, at what age? _____                           | Y / N / Don't Know |
| (4.) Died with no known reason?  | Y / N / Don't Know |
| (5.) Died while exercising? If yes, was it during or after? (Circle one.)                        | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

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**4. Have you ever had, or do you currently have, any of the following eye, ear, nose, mouth or throat conditions:**

- |   |                    |
|---|--------------------|
| a. Vision problems?   | Y / N / Don't Know |
| (1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.) | Y / N / Don't Know |
| b. Hearing loss or problems?  | Y / N / Don't Know |
| (1.) Wear hearing aides or implants?  | Y / N / Don't Know |
| c. Nasal fractures or frequent nose bleeds?                                 | Y / N / Don't Know |
| d. Wear braces, retainer or protective mouth gear?                          | Y / N / Don't Know |
| e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

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**5. Have you ever had, or do you currently have, any of the following neuromuscular/orthopedic conditions:**

- |   |                    |
|---|--------------------|
| a. Numbness, a "burner", "stinger" or pinched nerve?      | Y / N / Don't Know |
| b. A sprain?  | Y / N / Don't Know |
| c. A strain?  | Y / N / Don't Know |
| d. Swelling or pain in muscles, tendons, bones or joints? | Y / N / Don't Know |
| e. Dislocated joint(s)?                                   | Y / N / Don't Know |
| f. Upper or lower back pain?                              | Y / N / Don't Know |
| g. Fracture(s), stress fracture(s), or broken bone(s)?    | Y / N / Don't Know |
| h. Do you wear any protective braces or equipment?        | Y / N / Don't      |

Know

Explain all (yes) answers here (include relevant dates):

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6. **Have you ever had or do you currently have any of the following *general or exercise related conditions*:**
- |   |                    |
|---|--------------------|
| a. Difficulty breathing?  |                    |
| (1.) During exercise?   | Y / N / Don't Know |
| (2.) After running one mile?  | Y / N / Don't Know |
| (3.) Coughing, wheezing or shortness of breath in weather changes?              | Y / N / Don't Know |
| (4.) Exercise-induced asthma?   | Y / N / Don't Know |
| i. Controlled with medication? (specify _____)                                  | Y / N / Don't Know |
| ii. Experience dizziness, passing out or fainting?                              | Y / N / Don't Know |
| b. Viral infections (e.g. mono, hepatitis, coxsackie virus)?                    | Y / N / Don't Know |
| c. Become tired more quickly than others?                                       | Y / N / Don't Know |
| d. Any of the following skin conditions:  |                    |
| (1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts?                        | Y / N / Don't Know |
| (2.) Sun sensitivity?   | Y / N / Don't Know |
| e. Weight gain/loss (of 10 pounds or more)?                                     | Y / N / Don't Know |
| (1.) Do you want to weigh more or less than you do now?                         | Y / N / Don't Know |
| f. Ever had feelings of depression?   | Y / N / Don't Know |
| g. Heat-related problems (dehydration, dizziness, fatigue, headache)?           | Y / N / Don't Know |
| (1.) Heat exhaustion (cool, clammy, damp skin)?                                 | Y / N / Don't Know |
| (2.) Heat stroke (hot, red, dry skin)?  | Y / N / Don't Know |
| (3.) Muscle cramps?   | Y / N / Don't Know |
| h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

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7. **Females only:**

Age of onset of menstruation: \_\_\_\_\_ How many menstrual periods in the last twelve (12) months? \_\_\_\_\_  
 How many periods missed in the last twelve (12) months? \_\_\_\_\_

8. **Males only:**

Have you had any swelling or pain in your testicles or groin? Y / N / Don't Know

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

\_\_\_\_\_  
 Signature, Parent/Guardian or Student Age 18

\_\_\_\_\_  
 Date of Signature:

**THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.**

# ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

## Part B: Physical Evaluation Form

(Completed by the examining licensed provider MD, DO, APN or PA)

### -STUDENT INFORMATION-

Student's Name: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
 Sex: M F (circle one) Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 School: \_\_\_\_\_ District: \_\_\_\_\_  
 Parent/Guardian's Full Name: \_\_\_\_\_

### - EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

If conducted by school physician check here

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

### - FINDINGS OF PHYSICAL EVALUATION -

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Pulse: \_\_\_\_\_bpm.  
 Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it:   Louder           Softer           No Change
		Squatting makes it:   Louder           Softer           No Change
		Valsalva makes it:    Louder           Softer           No Change
Femoral Pulses	YES	
Lungs: Auscultation/Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Assessment of physical maturation or Tanner Scale	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	
Hernia	ABSENT	
Evidence of Marfan Syndrome	ABSENT	

**Most recent immunizations and dates administered:**

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**Medications currently prescribed, with dose and frequency:**

Medication Name	Dosage	Frequency

**Additional observations:**

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**General Diagnosis:**

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**General Recommendations:**

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**THE HISTORY PREPARED BY THE PARENT/STUDENT MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE PHYSICAL EXAMINATION.**

**CLEARANCES: (See notes at bottom for conditions requiring attention and for a list of sports by level of contact)**

- A. Student is cleared for participation in **all** sports without restriction.
- B. Student is **withheld clearance** for participation in any sport until evaluation / treatment of:  
\_\_\_\_\_  
\_\_\_\_\_
- C. Student is cleared for participation in **limited types** of sports which **exclude** the following types of sports contact: (CHECK ALL THAT APPLY)

CONTACT/COLLISION                       NON-CONTACT/STRENUOUS  
 LIMITED CONTACT                          NON-CONTACT/NON-STRENUOUS

Due to: \_\_\_\_\_

**HISTORY REVIEWED AND STUDENT EXAMINED BY:**

**Physician's/Provider's Stamp:**

Primary Care Provider  
School Physician Provider  
License Type:

MD/DO  
APN  
PA

PHYSICIAN'S/PROVIDER'S SIGNATURE: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Date of Exam: \_\_\_\_\_

**HISTORY REVIEWED BY:**

Name \_\_\_\_\_ Today's Date: \_\_\_\_\_  
SIGNATURE: \_\_\_\_\_ Review Date: \_\_\_\_\_

**RESERVED FOR SCHOOL DISTRICT USE**

## NOTES TO THE EXAMINING PROVIDER

Conditions requiring clearance before sports participation include, but are not limited to the following:

Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; Seizure Disorder; Marfan Syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

**SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT**

Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Basketball	Baseball	Discus	Bowling
Diving	Cheerleading	Javelin	Golf
Field Hockey	Fencing	Shot put	
Football	High Jump	Rowing	
Ice Hockey	Pole vault	Running/Cross Country	
Lacrosse	Gymnastics	Strength Training	
Soccer	Skiing	Swimming	
Wrestling	Softball	Tennis	
	Volleyball	Track	

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.

Effects of physiologic maneuvers on heart sounds:

Standing	Increases murmur of HCM Decreases murmur of AS, MR MVP click occurs earlier in systole
Squatting	Increases murmur of AS, MR, AI Decreases murmur of MCH MVP click delayed
Valsalva	Increases murmur of HCM Decreases murmur of AS, MR MVP click occurs earlier in systole

Physical Stigmata of Marfan's Syndrome

Kyphosis  
High arched palate  
Pectus excavatum  
Arachnodactyly  
Arm span > height 1.05:1 or greater  
Mitral Valve Prolapse  
Aortic Insufficiency  
Myopia  
Lenticular dislocation

HCM = Hypertrophic Cardio Myopathy

AS = Aortic Stenosis

AI = Aortic Insufficiency

MR = Mitral Regurgitation

MVP = Mitral Valve Prolapse