

STEP-BY-STEP GUIDE TO COMPLETE



Annual Sports Physical

PACKET

Please use a **PEN** on all Athletic
Physical Forms

Please fill out all highlighted
areas

Thank You, MO!

Mount Olive Department of Athletics

_____	AD
_____	Credits
_____	ATC
_____	Nurse
for official use only	

*Home
Of
The
Marauders*

_____	Eligible
_____	Ineligible
_____	Probation
_____	Red Shirt
For official use only	

Today's Date: _____ Date of Last Physical: _____

Student's Name: _____ Sex: M F (circle one) Age: _____ Place of Birth: _____
(City & State)

Address: _____

City/State/Zip: _____

Date of Birth: _____ Sport: _____ Home Phone: _____

Grade: _____ School: _____ District: _____

Physician: _____ Phone: _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to student: _____

Phone (work): _____ Phone (home): _____ Phone (cell): _____

***It is required that if your child goes to their private physician, the physician must sign and stamp stating completion of the cardiac module on the physical form. ***

Mount Olive Nurse's Office To Complete Information Below

Date of Physical _____

Physical performed by _____

The Family History Page

The Date of Examination must be
COMPLETED!!!

If you answer YES to any of the questions, you must explain the YES answer in the box provided, on the bottom right corner of the page

The Student **MUST** sign the form,
the Parent **MUST** sign & date the
form!!!!

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 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	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: Asthma Anemia Diabetes Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
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: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
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)?			40. Have you ever become ill while exercising in the heat?		
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?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
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)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			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 _____

Special Needs Form

Must be complete if applicable or N/A
written on page.

The Student Must sign the form,
the Parent MUST sign & date the
form!!!!

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 _____

The Physical Examination Form

Please put your child's name and date of
birth

ON EACH PAGE

**DO NOT LEAVE THE DOCTOR'S OFFICE IF
THE
HIGHLIGHTED AREAS ARE NOT
COMPLETED!!!**

❖ Physical Examination

- Height & Weight
- Blood Pressure
- Vision Screening, even if your child wears glasses, the exam must be done.
- Cleared/Not Cleared for Participation
- HCP Signature and Date

NOTE: The preparticipation physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practitioner nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

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 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?

Date of Physical Exam _____

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

EXAMINATION		Male	Female
Height	Weight		
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			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. ^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider 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 _____

The Clearance Form

Please put your child's name and date of birth

ON EACH PAGE

**DO NOT LEAVE THE DOCTOR'S OFFICE IF
THE
HIGHLIGHTED AREAS ARE NOT
COMPLETED!!!**

Cleared/NOT Cleared for Participation
Healthcare Provider's Office STAMP
Healthcare Provider's Signature and Date

❖ CARDIAC ASSESSMENT MODULE

- HCP Signature
- Date HCP completed the Module that is required in the State of NJ to perform Sport Physicals, will never be the same date the exam is being done!

**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 _____

Mount Olive High School

COREY ROAD, FLANDERS, NEW JERSEY 07836

Telephone Number (973) 927-2208

Nurse Fax Number (973) 927-2210

Kevin Moore, Principal

Dr. Sumit Bangia, Ed.D, Acting Superintendent of Schools

Susan Pasqualone, Vice Principal

David P. Falleni, Vice Principal

Robert Feltmann, Vice Principal for Student Affairs

Collen Suflay, Director of Athletics

Dear Parent/Guardian:

This letter serves as written notification that your son/daughter _____, can/cannot (circle one) participate in _____ sports for the 20____-20____ school year pursuant to N.J.A.C. 6A:16-2.2. Please be advised that this letter reflects the recommendation of the examining physician who **completed and signed** the Athletic Pre-Participation Examination Form submitted to the school on behalf of your son/daughter.

If your child is deemed unable to participate based on an incomplete form, please ensure that the original examining physician completes the form and returns it to the school to be reviewed for eligibility.

Remarks:

Sincerely,

Physician's Stamp _____ Date _____

Physician's Signature _____

****If your child has Asthma, a
Life Threatening Allergy
requiring an
Epinephrine Pen, Diabetes, or a
Seizure Disorder ****

Your Child's Physical
Examination will not be
processed for Medical
Clearance by our School
Physician if we do not have a
copy of those forms
on file in the Nurse's Office!
**These orders expire on the Last
Day of the**

School Year Per NJ Statute!

PLEASE submit all forms at least
14 DAYS prior to the 1st day of practice

- ❖ Once all forms are completed and handed into the Nurse's Office. The forms must be reviewed by the Nurse to see if all required areas are completed.
- The forms are then submitted to the School Physician for clearance
- Once clear by the Physician, Athletics will be notified
- Final clearance is through the Athletics Department