This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student-Athlete Cardiac Assessment Professional Development module hosted by the New Jersey Department of Education.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Unsure**	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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■ PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name:_____ Date of birth: _____

1. Type of disability:
2. Date of disability:
3. Classification (if available):
4. Cause of disability (birth, disease, injury, or other):
5. List the sports you are playing:

	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or 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 as having 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 whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (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 questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

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, e-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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) _____		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

J. Brooks Hoffman '36 Health Center
Blair Academy

healthcenter@blair.edu
(phone) (908)362-2010 (fax) 908-362-7885

Immunization History Form

To be completed by HealthCare Provider

STUDENT NAME: _____**DATE of BIRTH:**_____

ALL NEW STUDENTS: New Jersey Immunization Requirements are listed here; please have your HealthCare Provider complete the grid. Provider's office form is also acceptable with Office Stamp.

RETURNING STUDENTS: Please have your HealthCare Provider List ***ONLY*** newly received vaccines in the grid.

The Following Vaccines are REQUIRED for school attendance by the State of New Jersey:

4 doses	**Tetanus, diphtheria & acellular pertussis**	• 1 dose on or after 4th birthday • usually given as DTaP or DTP or DT or Td
1 dose	**Tdap**	• after 10th birthday
4 doses	**Polio**	• 4 doses (4th dose not required if the third dose was given age 4 or over and at least 6 months after the previous dose). • Lab titer is NOT acceptable. IPV and tOPV are acceptable on a schedule that mirrors CDC recommendations. • If a child only received tOPV and doses were given before age 4, one dose of IPV at 4 yrs or older must be given- at least 6 months after last tOPV dose
2 doses	**MMR**	• 1st dose after 1st birthday or lab titer with evidence of immunity
3 doses	**Hepatitis B**	• **The minimum interval between the first and second dose:** Weeks after first dose - 4 weeks (28 days) • **There are three minimum intervals that must be met for the third dose:** Weeks after first dose - 16 weeks (112 days) Weeks after second dose - 8 weeks (56 days) Weeks after birth - 24 weeks (168 days) • If the first three doses do not meet the required minimum intervals above, a lab titer or 4th dose is required.
2 doses	**Meningococcal (ACYW)**	• 1st dose given 11-15 years old; a second dose recommended at age 16 • If the first dose is given at age 16 or older, only one dose is required
1 dose	**Varicella**	• One dose is required, or a statement of disease from Health Care Provider or Parent.
	Tuberculosis Screening Required by Blair Academy **Please schedule with your Health Care Provider at the time of your physical**	• ALL domestic students ,must have a Tuberculosis Screening with either Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) Blood Test upon entry to Blair Academy (valid for their tenure at Blair). Please schedule with your Healthcare provider at the time of your physical appointment.. • **ANNUALLY**, ALL international students from **High Burden TB countries** must have either a Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) Blood Test within 12 weeks prior to the start of the school year.

J. Brooks Hoffman '36 Health Center
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Immunization History Form

To be completed by HealthCare Provider

STUDENT NAME: _____**DATE of BIRTH:**_____

ALL NEW STUDENTS: New Jersey Immunization Requirements are listed here; please have your HealthCare Provider complete the grid. Provider's office form is also acceptable with Office Stamp.

RETURNING STUDENTS: Please have your HealthCare Provider List ***ONLY the newly*** received vaccines in the grid.

RECORD DATES with EXACT MONTH, DAY, YEAR (MM/DD/YYYY)

	1	2	3	4	5
DTaP, DPT, DT, TD					
Tdap (1 dose)					
Polio (OPV/IPV)					
MMR (2 doses)					
Hepatitis B (3 doses)					
Varicella Vaccine (1 dose or Lab Titer)					
Meningococcal ACYW					
Other Optional Vaccines (Please list here if applicable)					

Tuberculosis (TB) Assessment and Testing

- **ALL STUDENTS(Returning,New, Domestic and International) must have their Health Care Provider complete this section.**
- **ALL domestic students are required to have one Tuberculin Skin Test (TST) or Interferon Gamma Release Assay IGRA BLOOD TEST for TB within 12 weeks of start of school. This will be valid for their four year tenure at Blair.**
- **Annually,** ALL international students must follow NJ State Mandates. If your child comes from a country not listed on page 3 of the NJ State Mandate, they must have either a Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) Blood Test within 12 weeks prior to the start of the school year, The student is **REQUIRED** to have an **Tuberculin Skin Test (TST) or IGRA BLOOD TEST** no more than 12 weeks prior to attending school. If the TB test is positive, provide a chest x-ray report and details of any medication treatment below. Please submit copies of any lab work and chest x-ray results if applicable to healthcenter@blair.edu .

Furthermore, indicate if the student was previously diagnosed with ACTIVE or LATENT tuberculosis infection (Date) _____

Circle test performed

Tuberculin Skin Test Date Placed_____ Date Read_____Result_____Induration (mm)_____

Blood Test (QFT Gold Plus, T-Spot, other)_____ Date_____Result _____

Chest X-ray Date: _____ Result:_____

Treatment Details: _____

Date form completed: _____

Please note Health Care provider must be someone other than a parent

HealthCare Provider Signature:_____

Healthcare Provider Name (Please Print):_____

Office Stamp: