Medical Eligibility Form Participation Checklist

Please read the following instructions carefully. If your child is submitting a new medical eligibility form please refer to Section 1. If your child has submitted a medical eligibility form AND had a physical exam more than 90 days ago please skip ahead to Section 2.

Please return the completed checklist and required form to the nurse.

Section 1: Pre-Participation Physical Evaluation Medical Eligibility Form-

This form is needed if:

- **Your child had their last physical examination more than a year ago, OR**
- **We don't already have a Pre-Participation Physical Evaluation Medical Eligibility Form in the nurse's office.**

Step 1: Please fill out the Athletic Information Form on page 1 of the packet. Your sport **MUST** be listed. This form is to be returned to the school nurse.

- Completed Athletic Information Form (page 1)

Step 2: The Medical Eligibility Form (page 2) **MUST** be filled out in its entirety by your child's physician. A doctor's signature is **required**. This form is to be returned to the school nurse.

- Completed Medical Eligibility Form (page 2)
- Form is signed by your child's examining physician
- Date of exam is listed on the form
- Emergency contact information is completed at the bottom

Step 3: IF YOUR CHILD HAS ASTHMA OR AN ALLERGY, the Asthma and Allergy Forms (pages 3-6) **MUST** be completed, stamped, and signed by your child's physician. These forms are to be returned to the school nurse. If your child **does not have** asthma or an allergy you may **disregard** the forms and move to Section 4 of the checklist.

- Asthma Treatment Plan completed, signed and stamped by my child's physician
- Allergy and Anaphylaxis Emergency Plan completed, signed, and stamped by my child's physician
- My child does not have Asthma and/or Allergies

Step 4: Preparticipation Physical Evaluation Forms (pages 7-10-the red forms) are to be completed and kept by your child's physician. **They are NOT to be returned to the school nurse.**

Section 2: Health History Update Form- If your child's last physical was MORE than 90 days ago and the Pre-Participation Physical Evaluation Medical Eligibility Form has been completed and sent to the school nurse, the Health History Update Form is required. This form is to be filled out in its entirety by the parent/guardian. A doctor's signature is NOT required. Please return the completed form to the school nurse.

Step 1: Please fill out the Athletic Information Form on page 1 of the packet. Your sport **MUST** be listed. This form is to be returned to the school nurse.

- Completed Athletic Information Form (page 1)

Step 2: The Health History Update Questionnaire (page 2) is to be filled out in its entirety by the parent and/or guardian. **Any questions answered "yes" should be explained in the boxes provided on the form.** The form MUST be signed by a parent or guardian and returned to the school nurse.

- Completed and signed Health History Update Questionnaire (page 2)

You will receive an email from the Athletic Trainers; Sean Conroy/Justin Corcoran, once your child has been cleared for participation.

STOP

PLEASE READ HIGHLIGHTED RED WRITING AT THE TOP OF EACH PAGE BEFORE COMPLETING

COMPLETE AND RETURN TO SCHOOL NURSE

Mount Olive Township School District

ATHLETIC INFORMATION FORM

Marauders Athletic Department

Dig Deep, Dream Big, Have Fun

Athletic Trainer Form

___ Reviewed by Health Office

___ Online Registration Completed

___ Final Clearance granted by Athletic Training Office

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

Students Name:____________________ Sex M F (circle) Age:____ DOB:______________

Address:____

City/State/Zip:____

Main Phone:________________ School:__________________ Grade:__________________

Physician:___________________ Phone:______________ Fax:___________________

IT IS REQUIRED THAT THE EXAMINING PHYSICIAN MUST SIGN INDICATING COMPLETION OF THE CARDIAC MODULE ON THE PHYSICAL FORM

Mount Olive Nurse's Office To Complete Information Below

Date of Physical____

Physical Performed By_____________________________________

****IN ORDER TO RECEIVE FINAL ATHLETIC CLEARANCE, PLEASE ENSURE THAT ONLINE ACTIVITY REGISTRATION IS COMPLETE & YOU HAVE SUBMITTED REQUIRED ANNUAL MEDICAL PLANS****

RETURN THIS FORM TO THE SCHOOL

PHYSICIAN COMPLETES THEN RETURN TO SCHOOL NURSE

Preparticipation Physical Evaluation Medical Eligibility Form

The Medical Eligibility Form is the only form that should be submitted to school. It should be kept on file with the student's school health record.

Student Athlete's Name ____ Date of Birth ________________________

Date of Exam ____

- ○ Medically eligible for all sports without restriction
- ○ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of
- ○ Medically eligible for certain sports
- ○ Not medically eligible pending further evaluation
- ○ Not medically eligible for any sports

Recommendations: ____

I have reviewed the history form and examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings- are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Signature of physician, APN, PA ______________________________ Office stamp (optional)

Address: ____

Name of healthcare professional (print) _________________________

I certify I have completed the Cardiac Assessment Professional Development Module developed by the New Jersey Department of Education.

Signature of healthcare provider ____

Shared Health Information

Allergies ____

Medications:

Other information: ____

Emergency Contacts: ____

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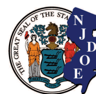
**This form has been modified to meet the statutes set forth by New Jersey.*

IF STUDENT HAS ASTHMA HAVE PHYSICIAN COMPLETE AND RETURN TO SCHOOL NURSE

Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) **(Physician's Orders)**



(Please Print)

Name		Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)	Emergency Contact	
Phone	Phone	Phone	

HEALTHY (Green Zone)

You have ***all*** of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above ___________

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take____________________ ____ puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

You have ***any*** of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:___________

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from______ to______

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY (Red Zone)

Your asthma is getting worse fast:
- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:_______________

And/or Peak flow below _________

Take these medicines NOW and CALL 911.
Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ❏ Colds/flu
- ❏ Exercise
- ❏ Allergens
  - ❍ Dust Mites, dust, stuffed animals, carpet
  - ❍ Pollen - trees, grass, weeds
  - ❍ Mold
  - ❍ Pets - animal dander
  - ❍ Pests - rodents, cockroaches
- ❏ Odors (Irritants)
  - ❍ Cigarette smoke & second hand smoke
  - ❍ Perfumes, cleaning products, scented products
  - ❍ Smoke from burning wood, inside or outside
- ❏ Weather
  - ❍ Sudden temperature change
  - ❍ Extreme weather - hot and cold
  - ❍ Ozone alert days
- ❏ Foods:
  - ❍ ___________
  - ❍ ___________
  - ❍ ___________
- ❏ Other:
  - ❍ ___________
  - ❍ ___________
  - ❍ ___________

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

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REVISED MAY 2017

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Permission to Self-administer Medication:

☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is <u>not</u> approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE_____________________ DATE_________

Physician's Orders

PARENT/GUARDIAN SIGNATURE_____________________

PHYSICIAN STAMP

Make a copy for parent and for physician file, send original to school nurse or child care provider.

Asthma Treatment Plan – Student
Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. Parents/Guardians: *Before taking this form to your Health Care Provider,* complete the top left section with:
- Child's name
- Child's date of birth
- Child's doctor's name & phone number
- An Emergency Contact person's name & phone number
- Parent/Guardian's name & phone number

2. Your Health Care Provider will complete the following areas:
- The effective date of this plan
- The medicine information for the Healthy, Caution and Emergency sections
- Your Health Care Provider will check the box next to the medication and check how much and how often to take it
- Your Health Care Provider may check **"OTHER" and:**
  - ❖ **Write in asthma medications not listed on the form**
  - ❖ **Write in additional medications that will control your asthma**
  - ❖ **Write in generic medications in place of the name brand on the form**
- Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:
- Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Child's asthma triggers on the right side of the form
- Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. Parents/Guardians: *After completing the form with your Health Care Provider:*
- Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
- Keep a copy easily available at home to help manage your child's asthma
- Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

____________________________ Parent/Guardian Signature   ______________ Phone   __________ Date

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be **ALLOWED** to carry the following medication ____________________ for self-administration in school pursuant to N.J.A.C:.6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ I **DO NOT** request that my child self-administer his/her asthma medication.

____________________________ Parent/Guardian Signature   ______________ Phone   __________ Date

PACNJ
Pediatric/Adult Asthma Coalition

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IF STUDENT HAS AN ALLERGY HAVE PHYSICIAN COMPLETE AND RETURN TO SCHOOL NURSE

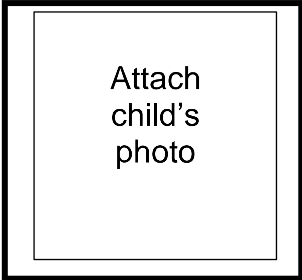
Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: ___________________________________ **Date of plan:** _________________

Date of birth: ____/____/______ **Age** ______ **Weight:** _________kg

Child has allergy to ____



Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

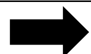
- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION**: If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): ____________________. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.

Give epinephrine! What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction What to look for



If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type): ___________________________________Dose: ☐ 0.10 mg (7.5 kg to less than13 kg)*
☐ 0.15 mg (13 kg to less than 25 kg)
☐ 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): ________________________________ (*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): ____

_________________________________ ______________ _______________________________ _____________

Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

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This information should not take the place of talking with your child's doctor.

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Child's name: ____ **Date of plan:** ________________________________

Additional Instructions:

Contacts

Call 911 / Rescue squad: ____________________________

Doctor: ____ Phone: ______________________

Parent/Guardian: ____ Phone: ______________________

Parent/Guardian: ____ Phone: ______________________

Other Emergency Contacts

Name/Relationship: ____ Phone: ______________________

Name/Relationship: ____ Phone: ______________________

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This information should not take the place of talking with your child's doctor.

STOP MUST READ BOX DO NOT RETURN TO SCHOOL NURSE

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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STOP MUST READ BOX DO NOT RETURN TO SCHOOL NURSE

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.

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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STOP MUST READ BOX DO NOT RETURN TO SCHOOL NURSE

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)

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

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