

Highland Regional High School Sign-up & Registration Information Athletics and Indoor Percussion

To participate in athletics or indoor percussion at Highland High School, students must complete all the items in the following checklist. The school physician must review the preparticipation health form before a student can participate. Failing to complete these steps promptly may delay your child's participation clearance. All forms and directions are on Highland's athletic department webpage: <https://www.bhprsd.org/domain/1231>

Step 1 - Complete athletic registration in the Genesis Parent Access Portal

Highland's Athletic Department uses the Genesis Parent Portal for Athletic Participation Forms. All forms must be completed by a parent or legal guardian prior to each sports season (fall, winter, and spring).

→ Once logged in, click FORMS at the top, and complete the "Optional Sports Participation Form"

Genesis Parent Portal: <https://parents.bhprsd.org/genesis/parents?gohome=true>

For assistance with Parent Access contact Highland's Counseling Office at (856) 227-4100 ext 4037.

Step 2 – Complete all Health Forms

Each student-athlete and indoor percussion participant must turn in an up-to-date Preparticipation Physical Evaluation Medical Eligibility Form to the school nurses' office for review by the school physician before athletic/percussion participation begins per New Jersey state law. All questions about your child's eligibility should be directed to our school nurse.

Hard copies of the forms are available to pick up at Highland or to print from Highland's athletic department webpage: <https://www.bhprsd.org/domain/1231>

Step 3 - ImPACT Baseline Test

All 9th grade, 11th grade, and transfer students must complete the ImPact Baseline Test. If the student is currently being treated by a doctor for a concussion, do not take the test. Instead, contact the Athletic Trainer or nurse ASAP. All questions concerning the ImPACT test can be directed to the Athletic Training Office at (856) 227-4100 ext 4100.

ImPACT Test directions can be found on the next page of this packet.

- ★ Please be aware that completing the registration process and the physician's physical exam does **NOT** guarantee the student's eligibility to participate. Athletic eligibility is contingent upon:
- Completed physical packet paperwork
 - A valid physical (good for 365 days)
 - Academic requirements/credits
 - Behavioral/conduct requirements
 - No outstanding fees/fines

ImPACT

All athletes, Pep band, and drumline participants must complete the baseline ImPACT testing before being allowed to participate in their activity. ImPACT is a computerized concussion evaluation system that measures verbal and visual memory, processing speed, and reaction time. To most effectively care for participants who have sustained concussions, it is helpful to compare baseline data to post-concussion data so that any deficits can be determined and proper return-to-play decisions can be made.

INSTRUCTIONS FOR ATHLETES

Please understand that you cannot “fail” this test. It is extremely important, however, that you:

1. Set aside 30 minutes in a quiet place with NO DISTRACTIONS.
2. READ the instructions very carefully. Failure to do this can affect the test results and you may then have to re-take the test.
3. If you do not have Internet access at home and are unable to take the test anywhere else, please contact your school’s athletic trainer.

TAKING THE TEST:

1. Using a computer with a keyboard open the web browser
2. Go to www.impacttestonline.com/schools/
3. Enter Highland’s Customer Code: ADDB273F4E
4. Click “Validate” then “Launch Test”
5. Follow the directions. Make sure to read all instructions!

ANY QUESTIONS OR CONCERNS SHOULD BE DIRECTED
TO YOUR SCHOOL’S CERTIFIED ATHLETIC TRAINER LISTED BELOW

| | | |
|--|---|--|
| Highland Regional High School Customer ID Code: <u>ADDB273F4E</u> Gavin Orr (856) 227-4100, ext. 4100 gorr@bhprsd.org | Triton Regional High School Customer ID Code: <u>44907883D4</u> Rachel Pantaleo (856) 939-4500, ext. 2078 rpantaleo@bhprsd.org | Timber Creek Regional High School Customer ID Code: <u>542D7DC4DA</u> Dominic Acchitelli (856) 232-9703, ext. 6050 dacchitelli@bhprsd.org |
|--|---|--|

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.

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? | | | |

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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■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance) PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

- 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?
- Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form).

| EXAMINATION | | |
|--|---------|--|
| Height: | Weight: | |
| BP: / (/) | Pulse: | Vision: R 20/ L 20/ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N |
| COVID-19 VACCINE | | |
| Previously received COVID-19 vaccine: <input type="checkbox"/> Y <input type="checkbox"/> N | | |
| Administered COVID-19 vaccine at this visit: <input type="checkbox"/> Y <input type="checkbox"/> N If yes: <input type="checkbox"/> First dose <input type="checkbox"/> Second dose <input type="checkbox"/> Third dose <input type="checkbox"/> Booster date(s) _____ | | |
| MEDICAL | NORMAL | ABNORMAL FINDINGS |
| Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | | |
| Eyes, ears, nose, and throat <ul style="list-style-type: none"> Pupils equal Hearing | | |
| Lymph nodes | | |
| Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | | |
| Lungs | | |
| Abdomen | | |
| Skin <ul style="list-style-type: none"> Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (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 <ul style="list-style-type: none"> 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

This page is to be completed by Parent/Guardian and Physician

Form 4

Black Horse Pike Regional School District - Medication - Dispensing Form

List only one medication on a form, additional forms available upon request.

Parent

PARENTS SHOULD FILL OUT THE BOLDED AREAS

I request the enclosed medication, in the original container, to be administered to my child and shall release school personnel from all liability. I give the School Nurse permission to contact the physician and/or pharmacist with any question concerning the medication.

Name of Child _____

Name & Strength of Medication _____

Dosage _____

Signature of Parent/Guardian X _____

INHALER AND EPI-PEN PATIENTS ONLY

In case of ASTHMA or potentially life threatening illness, will the student be giving himself/herself this medication?
 Yes No **If yes, please sign below**

We the parents or guardians of the pupil, acknowledge that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and that we shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the pupil. The permission is effective for the school year for which it is granted.

Signature of Parent/Guardian X _____ **Date** _____

Both sections must have completed information and required signatures.

Doctor

DOCTORS MUST COMPLETE ALL BOLDED INFORMATION

Students Name _____ **Age** _____ **Grade** _____ **School** _____

Name & Strength of Medication _____ **Dosage** _____

Time & Route of Administration in School _____

Reason for Medication _____

Effective Dates: from _____ **to** _____

Most common side effects: _____

It is my understanding the School Nurse charged with the administration of medication may rely upon my direction as contained in this document. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment. Any alteration to the above will occur only with written directions from the attending physician.

Doctor's Name (Print)

Doctor's Signature

Patient's Medication Allergies

Doctor's Address

Date

Doctor's Telephone Number

INHALER AND EPI-PEN PATIENTS ONLY

I certify that the pupil has asthma or another life threatening illness and is capable of, and has been instructed in, the proper method of self-administration of medication.

In case of ASTHMA or potentially life threatening illness, will the student be giving himself/herself this medication?
 Yes No **Doctor's Signature REQUIRED**