

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?			

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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: ☐ 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 <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 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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■ 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: _____

Asthma Treatment Plan – Student

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



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

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

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 **not** approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE _____

Physician's Orders

DATE _____

PARENT/GUARDIAN SIGNATURE _____

PHYSICIAN STAMP

Disclaimer: The use of this Asthma Action Plan is intended to assist in the management of asthma, but it is not a substitute for medical advice. The Asthma Action Plan is not a medical device and is not intended to be used in place of medical advice. The Asthma Action Plan is not a medical device and is not intended to be used in place of medical advice. The Asthma Action Plan is not a medical device and is not intended to be used in place of medical advice.

REVISED MAY 2017

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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 doctor's name & phone number
- Parent/Guardian's name & phone number
- Child's date of birth
- An Emergency Contact person'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

NEW JERSEY STATE INTERSCHOLASTIC ATHLETIC ASSOCIATION

1161 Route 130 North, Robbinsville, NJ 08691-1104

STUDENT-ATHLETE RESIDENCY AFFIDAVIT

Print Student's Full Name

School

Date

I, _____, of full age, being duly sworn to law, upon my oath
depose and say:

1. I am the parent/legal guardian of the above listed student. (circle)

2. I currently reside at: _____

I have resided at the above address since: _____

3. The above-named student moved with me at my new address on: _____

4. Prior to moving to the new residence address listed above, I resided at the following address:

5. Prior to moving to the new address listed in #2 above, the student resided at the following address:

with named parent/legal guardian _____

6. I hereby authorize the New Jersey State Interscholastic Athletic Association ("NJSIAA") to investigate and confirm any and all Statements made by me in this affidavit. I agree to provide any additional information that may be requested by the NJSIAA.

7. I will notify the present school immediately, in writing, if any of the conditions recited herein are changed.

8. This residence may not be associated with, leased, or provided by anyone associated with the school or acting at the direction of the school, including but not limited to administration, staff, coaches, students, parents, booster clubs, or any organization having a connection with the school.

I hereby certify that the forgoing statements are true; and I am aware that if any of the foregoing statements are willfully false, I am subject to punishment.

Parent/Guardian Signature

Print Parent/Guardian Full Name

STATE OF NEW JERSEY, COUNTY OF _____. The above-named affiant appeared before me, a notary public of the State of New Jersey, on the _____ day of _____, 20____ and I made known to him/her the contents of the above affidavit which was then sworn and subscribed to by said affiant before me on this date.

Notary Public: _____

Copies of this Affidavit must be sent to the New Jersey State Interscholastic Athletic Association upon request

Incoming Transfer Student Information

Name of Present School: Audubon High School	
Student Name:	Student's Date of Birth:

Date of Enrollment at Present School. If enrollment occurs after the beginning of the school year, Month, Day, Year, student first attended class:	School Choice Student: Yes ☐ No ☐
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Previous School Information

Name of Previous School:	City:
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Date of withdrawal:	Student first attended 9 th grade/school:	Date:
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Parent/Guardian PREVIOUS Address:

List all sports in which the student participated on a varsity level in sports season during the calendar year

1.	2.	3.
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Has the student participated in a 9-12 program while in the 6 th , 7 th , or 8 th grade?	
Yes ☐	No ☐

Is this the students first transfer?	
Yes ☐	No ☐

How many high schools has this student attended prior to enrolling in this school?
Please list the schools below:
1.
2.
3.

Both sides must be completed – see reverse →