

# New Jersey Department of Education ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the parent and student and reviewed by examining provider

Part B: PHYSICAL EVALUATION FORM-Completed by examining licensed provider with MD, DO, APN or PA

## Part A: HEALTH HISTORY QUESTIONNAIRE

**Today's Date:** \_\_\_\_\_ **Date of Last Sports Physical:** \_\_\_\_\_

**Student's Name:** \_\_\_\_\_ **Sex:** M F **Age:** \_\_\_\_ **Grade:** \_\_\_\_ **Home Phone #** \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **School:**  Green Brook Middle School ---  IEF Elementary School **District:** Green Brook Township

**Sport (s):** Soccer, Cross Country, Basketball, Track, Softball, Baseball, Girls on the Run (Circle all that apply)

**Provider's Name (Medical Home):** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

### Emergency Contact Information

Mother/Guardian's Name: _____	Father's/Guardian's Name: _____
Cell # _____ Work# _____	Cell # _____ Work# _____

Additional Emergency Contact: _____	Relationship to Student: _____	Cell # _____	Home# _____
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### Health History Information

**Directions:** Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below each section. **Respond to all questions.**

<b>1. Have you ever had, or do you currently have:</b>	Y / N / Don't Know
a. Restriction from sports for a health related problem.	Y / N / Don't Know
b. An injury or illness since your last exam?	Y / N / Don't Know
c. A chronic or ongoing illness (such as diabetes or asthma)?	Y / N / Don't Know
1.) An inhaler or other prescription medicine to control asthma?	Y / N / Don't Know
d. Any prescribed or over the counter medications that you take on a regular basis?	Y / N / Don't Know
e. Surgery, hospitalization or any emergency room visit(s)?	Y / N / Don't Know
f. Any <b>allergies</b> to medications?	Y / N / Don't Know
g. Any allergies to bee stings, pollen, latex or foods?	Y / N / Don't Know
(1.) If yes, check type of reaction:	Y / N / Don't Know
<input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Breathing or other anaphylactic reaction	
(2.) Take any medication/Epi-pen taken for allergy symptoms? (List below.)	Y / N / Don't Know
h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders?	Y / N / Don't Know
i. A blood relative who died before age 50?	Y / N / Don't Know
▶ Explain all "yes" answers here (include relevant dates):	

#### MEDICATIONS: List all medications here:

Medication Name:	Rationale Or Indication:	Dosage	Frequency/Times Given

<b>2. Have you ever had, or do you currently have, any of the following HEAD-related conditions:</b>	Y / N / Don't Know
a. Concussion or head injury (including "bell rung" or a "ding")?	Y / N / Don't Know
b. Memory loss?	Y / N / Don't Know
c. Knocked out?	Y / N / Don't Know
d. A seizure(s)?	Y / N / Don't Know
e. Frequent or severe headaches (With or without exercise)?	Y / N / Don't Know
f. Fuzzy or blurry vision	Y / N / Don't Know
g. Sensitivity to light/noise	Y / N / Don't Know
▶ Explain all "yes" answers here (include relevant dates):	

<b>3. Have you ever had, or do you currently have, any of the following HEART-related conditions:</b>	Y / N / Don't Know
a. Restriction from sports for heart problems?	Y / N / Don't Know
b. Chest pain or discomfort?	Y / N / Don't Know
c. Heart murmur?	Y / N / Don't Know
d. High blood pressure?	Y / N / Don't Know
e. Elevated cholesterol level?	Y / N / Don't Know
f. Heart infection?	Y / N / Don't Know
g. Dizziness or passing out during or after exercise without known cause?	Y / N / Don't Know

h. Has a provider ever ordered a heart test ( EKG, echocardiogram, stress test, Holter monitor)?	Y / N / Don't Know
i. Racing or skipped heartbeats?	Y / N / Don't Know
j. Unexplained difficulty breathing or fatigue during exercise?	Y / N / Don't Know
k. Any family member (blood relative):	
(1). Under age 50 with a heart condition?	Y / N / Don't Know
(2). With Marfan Syndrome?	Y / N / Don't Know
(3). Died of a heart problem before age 50? If yes, at what age?	Y / N / Don't Know
(4). Died with no known reason?	Y / N / Don't Know
(5). Died while exercising? If yes, was it during or after? (Circle one.)	Y / N / Don't Know
► Explain all "yes" answers here (include relevant dates):	
<b>4. Have you ever had, or currently have, any of the following <i>EYE, EAR, NOSE, MOUTH or THROAT</i> conditions:</b>	
a. Vision problems?	Y / N / Don't Know
(1). Wear contacts, eyeglasses or protective eye wear? (Circle which type.)	Y / N / Don't Know
b. Hearing loss or problems?	Y / N / Don't Know
(1). Wear hearing aides or implants?	Y / N / Don't Know
c. Nasal fractures or frequent nose bleeds?	Y / N / Don't Know
d. Wear braces, retainer or protective mouth gear?	Y / N / Don't Know
e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)?	Y / N / Don't Know
► Explain all "yes" answers here (include relevant dates):	
<b>5. Have you ever had, or do you currently have, any of the following <i>NEUROMUSCULAR/ORTHOPEDIC</i> conditions:</b>	
a. Numbness, a "burner", "stinger" or pinched nerve?	Y / N / Don't Know
b. A sprain?	Y / N / Don't Know
c. A strain?	Y / N / Don't Know
d. Swelling or pain in muscles, tendons, bones or joints?	Y / N / Don't Know
e. Dislocated joint(s)?	Y / N / Don't Know
f. Upper or lower back pain?	Y / N / Don't Know
g. Fracture(s), stress fracture(s), or broken bone(s)?	Y / N / Don't Know
h. Do you wear any protective braces or equipment?	Y / N / Don't Know
► Explain all (yes) answers here (include relevant dates):	
<b>6. Have you ever had or do you currently have any of the following <i>GENERAL or EXERCISE RELATED</i> conditions:</b>	
a. Difficulty breathing?	Y / N / Don't Know
(1.) During exercise?	Y / N / Don't Know
(2.) After running one mile?	Y / N / Don't Know
(3.) Coughing, wheezing or shortness of breath in weather changes?	Y / N / Don't Know
(4.) Exercise-induced asthma?	Y / N / Don't Know
i. Controlled with medication? (specify _____)	Y / N / Don't Know
ii. Experience dizziness, passing out or fainting?	Y / N / Don't Know
b. Viral infections (e.g. mono, hepatitis, coxsackie virus)?	Y / N / Don't Know
c. Become tired more quickly than others?	Y / N / Don't Know
d. Any of the following skin conditions:	Y / N / Don't Know
(1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts?	Y / N / Don't Know
(2.) Sun sensitivity?	Y / N / Don't Know
e. Weight gain/loss (of 10 pounds or more)?	Y / N / Don't Know
(1.) Do you want to weigh more or less than you do now?	Y / N / Don't Know
f. Ever had feelings of depression?	Y / N / Don't Know
g. Heat-related problems (dehydration, dizziness, fatigue, headache)?	Y / N / Don't Know
(1.) Heat exhaustion (cool, clammy, damp skin)?	Y / N / Don't Know
(2.) Heat stroke (hot, red, dry skin)?	Y / N / Don't Know
(3.) Muscle cramps?	Y / N / Don't Know
h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)?	Y / N / Don't Know
► Explain all "yes" answers here (include relevant dates):	
<b>7. Females only:</b>	
a. Age of onset of menstruation: _____	
b. How many menstrual periods in the last twelve (12) months? _____	
<b>8. Males only:</b>	
a. Have you had any swelling or pain in your testicles or groin?	Y / N / Don't Know

**PARENT/GUARDIAN SIGNATURE**

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

**Printed Parent Name:** \_\_\_\_\_ **Signature date:** \_\_\_\_\_

**Parent/ Guardian or Student Age 18+ Signature:** \_\_\_\_\_

**THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.**

# ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

## Part B: Physical Evaluation Form

(Completed by the examining licensed provider MD, DO, APN or PA)

### -STUDENT INFORMATION-

Student's Name: \_\_\_\_\_ Sex: M F Grade: \_\_\_\_ Age: \_\_\_\_ Date of Birth: \_\_\_\_\_  
 Sport(s): Soccer, Cross Country, Basketball, Track, Softball, Baseball, Girls on the Run (Circle all that apply to this school year)

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

School:  Green Brook Middle School ---  IEF Elementary School District: Green Brook Township School District

Mother/Guardian's Name: \_\_\_\_\_ Father's/Guardian's Name: \_\_\_\_\_

Cell # \_\_\_\_\_ Work# \_\_\_\_\_ Cell # \_\_\_\_\_ Work# \_\_\_\_\_

### - EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

Check if conducted by school physician:  Practitioner's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

### - FINDINGS OF PHYSICAL EVALUATION -

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_/\_\_\_\_ Pulse: \_\_\_\_ bpm.

Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it: Louder Softer No Change
		Squatting makes it: Louder Softer No Change
		Valsalva makes it: Louder Softer No Change
Femoral Pulses	YES	
Lungs: Auscultation/Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Assess: physical maturation/Tanner Scale	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	
Hernia	ABSENT	
Evidence of Marfan Syndrome	ABSENT	

**Most recent immunizations and dates administered:**


**Medications currently prescribed, with dose and frequency:**

Medication Name	Dosage	Frequency

Additional observations:

General Diagnosis:

General Recommendations:

THE EXAMINING PROVIDER MUST REVIEW THE HISTORY PREPARED BY THE PARENT/STUDENT AT THE TIME OF THE PHYSICAL EXAMINATION.

CLEARANCES: (See notes at bottom for conditions requiring attention and for a list of sports by level of contact)

- A. Student is cleared for participation in all sports without restriction.
B. Student is withheld clearance for participation in any sport until evaluation and treatment of:
C. Student is cleared for participation in limited types of sports that exclude the following types of sports contact: (CHECK ALL THAT APPLY) CONTACT/COLLISION, LIMITED CONTACT, NON-CONTACT/STRENUOUS, NON-CONTACT/NON-STRENUOUS

Diagnosis:

Physician's/Provider's Stamp:

HISTORY REVIEWED AND STUDENT EXAMINED BY:

Primary Care Provider, School Physician Provider, License Type: MD/DO, APN, PA

PHYSICAL EXAM DONE BY: (PRINT)

PROVIDER'S SIGNATURE: Today's Date: Date of Exam:

HISTORY REVIEWED BY: Name (print) Today's Date:

REVIEWERS SIGNATURE: Review Date:

RESERVED FOR SCHOOL DISTRICT USE

NOTES TO THE EXAMINING PROVIDER

Conditions requiring clearance before sports participation include, but are not limited to the following: Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; Seizure Disorder; Marfan Syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

Table with 7 columns: Contact/Collision, Limited Contact, Strenuous, Non-strenuous, and sub-columns for each. Lists sports like Basketball, Ice Hockey, Baseball, Gymnastics, etc.

N.J.A.C. 6A:16-2.2 requires the school physician to provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this physical evaluation. This evaluation & notification letter is part of the student's school health record.

Table with 5 columns: Effects of physiologic maneuvers on heart sounds, Physical Stigmata of Marfan Syndrome, HCM = Hypertrophic Cardio Myopathy, and sub-columns for each. Lists effects like Standing, Squatting, Valsalva.