



# Southern Regional School District



## Middle School Athletic Department

609-597-9481x 4202

### **ATTENTION STUDENT ATHLETES** **Athletic Physicals for ALL 2010-11 Sports**

All students participating in an inter-scholastic sport must pass a physical examination for the current school year. You have the choice of using your own physician or the school physician. Follow the directions below.

**June 8** - current 7<sup>th</sup> & 8<sup>th</sup> graders who will play a fall sport and incoming 7<sup>th</sup> graders who will play football

**Aug. 17** – any incoming 7<sup>th</sup> grade student who will play a fall sport; and all female athletes playing a winter or spring sport

**Aug. 24** – all 2010-11 male students who will play a winter or spring sport

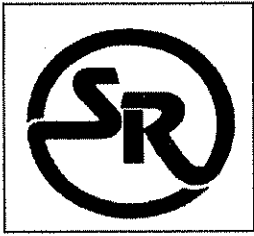
**Aug. 31** – by appointment only; contact Bob Schoka at 597-9481 x 4202

**\*\*Check [srsd.net](http://srsd.net) for times and locations.**

Using Your Own Doctor	Using the School Doctor
<ul style="list-style-type: none"> <li>✓ Be sure all pages in this booklet are filled out completely and signed where indicated.</li> <li>✓ For the Health History Questionnaire, be sure all "yes" responses have an explanation at the bottom of the page.</li> <li>✓ Your doctor must fill out and sign Part B, the Pre-Participation Physical Evaluation Form.</li> <li>✓ Do not fill out the Self-Medication Permission Form, <u>unless it is applicable.</u></li> <li>✓ Upon completion, return all forms to the Coach.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Be sure all pages in this booklet are filled out completely and signed where indicated.</li> <li>✓ For the Health History Questionnaire, be sure all "yes" responses have an explanation at the bottom of the page.</li> <li>✓ For Part B, the Pre-Participation Physical Evaluation Form, complete only the student section.</li> <li>✓ Do not fill out the Self-Medication Permission Form, <u>unless it is applicable.</u></li> <li>✓ Upon completion, return all forms to the Coach.</li> <li>✓ The dates for school physicals are listed above. These are the only days the school doctor will perform physicals; <u>there will be no make-up day.</u></li> </ul>

**Please do not separate the sheets in the booklet. Return all forms to your Coach by the designated deadline. Failure to do so may result in denial of an opportunity to participate.**

If you have any questions please call the Middle School athletic office at 597-9481, extension 4202.



**SOUTHERN REGIONAL MIDDLE SCHOOL**

Athletic Department

75 Cedar Bridge Road, Manahawkin, NJ 08050

(609)597-9481 x4202



**MEDICAL PERMIT**

Dear Parents:

According to the New Jersey Administrative Code (N.J.A.C. 6A:16-2.2), "each student's medical examination shall be conducted at the medical home of the student" (the student's physician or nurse practitioner/clinical nurse specialist). Since the school physician is a "healthcare provider", the parent/guardian may choose either the school physician or their own private physician to provide medical examination.

This form must be filled out and signed by the parent/guardian, indicating whether the student will be using the school physician or a private physician for the physician. PLEASE ONLY COMPLETE ONE SECTION.

HOME PHYSICIAN:

Student's Name \_\_\_\_\_ I.D. # \_\_\_\_\_

Homeroom Teacher \_\_\_\_\_

Sport \_\_\_\_\_ Grade as of Sept. 2010 \_\_\_\_\_

Student \_\_\_\_\_ will receive a physical from our home physician.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_



SCHOOL PHYSICIAN:

Student's Name \_\_\_\_\_ I.D. # \_\_\_\_\_

Homeroom Teacher \_\_\_\_\_ Grade as of Sept. 2010 \_\_\_\_\_

Sport \_\_\_\_\_

Student \_\_\_\_\_ designates the school physician as our home physician for the purpose of an athletic physical.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

# 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 (circle one) Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ School: \_\_\_\_\_ District: \_\_\_\_\_

Sport(s): \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Provider Name (Medical Home): \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name of parent/guardian: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

Additional emergency contact: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

**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 the questions. Please respond to all questions.

**1. Have you ever had, or do you currently have:**

- |  |                           |
|--|---------------------------|
| 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?  | <b>Y / N / Don't Know</b> |
| g. Any allergies to bee stings, pollen, latex or foods?  | Y / N / Don't Know        |
| (1.) If yes, check type of reaction:   |                           |
| <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Breathing or other anaphylactic reaction |                           |
| (2.) Take any medication/Epipen 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):

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**List all medications here:**

Medication Name	Dosage	Frequency

2. Have you ever had, or do you currently have, any of the following *head-related* conditions:

- 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
- c. A seizure? Y / N / Don't Know
- d. Frequent or severe headaches (With or without exercise)? Y / N / Don't Know
- e. Fuzzy or blurry vision Y / N / Don't Know
- f. Sensitivity to light/noise Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

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3. Have you ever had, or do you currently have, any of the following *heart-related* conditions:

- 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):

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4. Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat* conditions:

- 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):

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5. Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic* conditions:

- 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):

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6. Have you ever had or do you currently have any of the following *general or exercise related conditions*:
- a. Difficulty breathing?
    - (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:
    - (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):

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7. Females only:

Age of onset of menstruation: \_\_\_\_\_ How many menstrual periods in the last twelve (12) months? \_\_\_\_\_  
 How many periods missed in the last twelve (12) months? \_\_\_\_\_

8. Males only:

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.

\_\_\_\_\_  
 Signature, Parent/Guardian or Student Age 18

\_\_\_\_\_  
 Date of 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: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
 Sex: M F (circle one) Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 School: \_\_\_\_\_ District: \_\_\_\_\_  
 Parent/Guardian's Full Name: \_\_\_\_\_

### - EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

If conducted by school physician check here

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

### - 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	
Assessment of physical maturation or 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:

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Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Additional observations:

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General Diagnosis:

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General Recommendations:

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

**CLEARANCES: This section is completed by the examining healthcare provider.**

After examining the student and reviewing the medical history the student is:

- A. Cleared for participation in all sports without restrictions.
- B. Not cleared for participation in any sport until evaluation/treatment of:

\_\_\_\_\_

- C. Cleared for limited participation in the following types of sports only. Please see below for sport classifications. CHECK ALL THAT APPLY

\_\_\_ CONTACT/COLLISION  
\_\_\_ LIMITED CONTACT

\_\_\_ NON-CONTACT/STRENUOUS  
\_\_\_ NON-CONTACT/NON-STRENUOUS

Limitations due to: \_\_\_\_\_

**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's 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**

Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Basketball	Baseball	Discus	Bowling
Diving	Cheerleading	Javelin	Golf
Field Hockey	Fencing	Shot put	
Football	High Jump	Rowing	
Ice Hockey	Pole vault	Running/Cross Country	
Lacrosse	Gymnastics	Strength Training	
Soccer	Skiing	Swimming	
Wrestling	Softball	Tennis	
	Volleyball	Track	

**Effects of physiologic maneuvers on heart sounds**

- Standing
  - Increases murmur of HCM
  - Decreases murmur of AS, MR
  - MVP click occurs earlier in systole
- Squatting
  - Increases murmur of AS, MR, AI
  - Decreases murmur of MCH
  - MVP click delayed
- Valsalva
  - Increases murmur of HCM
  - Decreases murmur of AS, MR
  - MVP click occurs earlier in systole

**Physical Stigmata of Marfan's Syndrome**

- Kyphosis
- High arched palate
- Pectus excavatum
- Arachnodactyly
- Arm span > height 1.05:1 or greater
- Mitral Valve Prolapse
- Aortic Insufficiency
- Myopia
- Lenticular dislocation

- HCM: Hypertrophic Cardio Myopathy
- AS: Aortic Stenosis
- AI: Aortic Insufficiency
- MR: Mitral Regurgitation
- MVP: Mitral Valve Prolapse

HISTORY REVIEWED AND STUDENT EXAMINED BY: Physician's/Provider's Stamp:

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

PHYSICIAN'S/PROVIDER'S SIGNATURE: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

**RESERVED FOR SCHOOL DISTRICT USE**

NOTE: 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 and the notification letter become part of the student's school health record.

History and Physical Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

Title of Reviewer (please check one):  School Nurse  School Physician

Medical Eligibility Notification Sent to Parent/Guardian by School Physician \_\_\_\_\_  
Date

Letter of notification is attached.

OR

Parent notification indicates that:

- Participation Approved without limitations.
- Participation Approved with limitations pending evaluation.
- Participation NOT Approved

Reason(s) for Disapproval: \_\_\_\_\_  
\_\_\_\_\_

**PLEASE FILL OUT IF APPLICABLE**

**SOUTHERN REGIONAL MIDDLE SCHOOL**

**Athletic Department**

(609)597-9481, ext. 4202



**SELF-MEDICATION PERMISSION FORM**

*In accordance with Chapter 308, P.L. 1993, this form must be signed by the parents or guardians of any student who wishes to self-administer medication.*

We \_\_\_\_\_ and \_\_\_\_\_ (print names of parents) are the parents or guardians of \_\_\_\_\_ (print name of student), a student in the Southern Regional School district. As required by law, this form provides to the Southern Regional Board of Education, our written authorization for our child to self-administer medication. We further acknowledge, that by copy of this form, the Southern Regional School board has informed us that the district, its employees or agents, shall incur no liability as a result of any injury from the self-administration of medication by our child. Further, by signing this form, we release the Southern Regional School Board, its employees and agents, from any liability as a result of any injury from the self-administration of medication by our child, and we expressly agree to defend, protect, indemnify, and hold harmless the Southern Regional School District, and its employees or agents from all losses, costs, suits or claims which may result from the self-administration of medication by our child.

Signature of Parent \_\_\_\_\_

Date \_\_\_\_\_ Telephone \_\_\_\_\_

**PHYSICIAN CERTIFICATION FOR SELF-MEDICATION BY STUDENT**

In accordance with Chapter 308, P.L. 1993, I \_\_\_\_\_ (print name of Physician) certify that I am the physician of \_\_\_\_\_ (print student's name). This patient suffers from \_\_\_\_\_ (print name of illness), a potentially life-threatening illness, is capable of, and has been instructed in, the proper method of self-administration of medication for this illness.

Name of Medication \_\_\_\_\_ Dose/Route \_\_\_\_\_

Time \_\_\_\_\_ Additional Instructions \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Phone # \_\_\_\_\_ Date \_\_\_\_\_