

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:** _____ **District:** _____

Sport (s): _____

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

Emergency Contact Information

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

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

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

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

Student's name _____

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):		
4. Have you ever had, or currently have, any of the following <i>EYE, EAR, NOSE, MOUTH or THROAT</i> 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):		
5. Have you ever had, or do you currently have, any of the following <i>NEUROMUSCULAR/ORTHOPEDIC</i> 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):		
6. Have you ever had or do you currently have any of the following <i>GENERAL or EXERCISE RELATED</i> conditions:		
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):		
7. Females only:		
a.	Age of onset of menstruation: _____	
b.	How many menstrual periods in the last twelve (12) months? _____	
c.	How many missed periods in the last twelve (12) months? _____	
8. Males only:		
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: _____ **Sport(s):** _____
Address: _____ **City/State/Zip:** _____
Gender: M F **Age:** ____ **Date of Birth:** ____ / ____ / ____ **Grade:** ____ **Home Phone #** _____
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

Student's name _____

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: This section is completed by the examining health care 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 sports classifications .
(CHECK ALL THAT APPLY) ___ CONTACT/COLLISION ___ NON-CONTACT/ STRENUOUS
 ___ LIMITED CONTACT ___ NON-CONTACT/ NON-STRENUOUS

Limitations due to: _____

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: _____

RESERVED FOR SCHOOL DISTRICT USE

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.

History and Physical Reviewed By:	Title of Reviewer (please check one): <input type="checkbox"/> School Nurse <input type="checkbox"/> School Physician		Date
Medical Eligibility Notification Sent to Parent/Guardian by School Physician	<input type="checkbox"/> Letter of notification is attached.		
	OR		
Parent notification indicates that:	<input type="checkbox"/> Participation Approved without limitations.		
	<input type="checkbox"/> Participation Approved with limitations pending evaluation.		
	<input type="checkbox"/> Participation NOT Approved		
	Reason(s) for Disapproval: _____		

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

Contact/Collision		Limited Contact		Non-Contact			
				Strenuous		Non-strenuous	
Basketball	Ice Hockey	Baseball	Gymnastics	Discus	Running/Cross Country	Rowing	Bowling
Diving	Lacrosse	Cheerleading	Skiing	Javelin	Strength Training	Tennis	Golf
Field Hockey	Soccer	Fencing	Softball	Shot put	Swimming	Track	
Football	Wrestling	High Jump/ pole vault	Volleyball				
Effects of physiologic maneuvers on heart sounds:			Physical Stigmata of Marfan Syndrome		HCM = Hypertrophic Cardio Myopathy		
Standing	Squatting	Valsalva		Kyphosis	Mitral Valve Prolapse	AS = Aortic Stenosis	
Increases murmur of HCM	Increases murmur of AS, MR, AI	Increases murmur of HCM		Myopia	High arched palate	AI = Aortic Insufficiency	
Decreases murmur of AS, MR	Decreases murmur of MCH	Decreases murmur of AS, MR		Pectus excavatum	Lenticular dislocation	MR = Mitral Regurgitation	
MVP click occurs earlier in systole	MVP click delayed	MVP click occurs earlier in systole		Arachnodactyly & Arm span > height 1.05:1	Aortic Insufficiency	MVP = Mitral Valve Prolapse	