Alder Avenue Middle School
25 Alder Avenue
Egg Harbor Township, NJ 08234

School Nurse Phone **Fax:**
383-3366 **383-1492**

Dear Parent/Guardian:

Attached is the paperwork for you to complete **if your child is in need of a new physical (Fall, Winter, Spring) for your child to be "cleared" to participate in athletics**.
Once the packet is complete, please have your child return the packet to the school nurse. Please follow these steps.

1. Complete and sign the Permission for Participation in Athletics.
2. Read and sign the Sudden Cardiac Arrest Form.
3. Read and sign the NJSIAA Steroid Testing Policy Form.
4. Read and sign the Concussion Management Form.
5. Complete and sign the Sports Emergency Form.
6. Fill out and sign the Annual Pre-Participation Evaluation Form/Athlete with Special Needs Form. If you circle **"yes"** to any questions, please provide an explanation. If your child takes any medications (i.e. Inhaler, Benadry;, etc.) fill out the Meds at School form and have your **physician** sign it.
7. Please bring the Physical Evaluation Form to your child's doctor to fill out and sign. The physicals are valid for one calendar year (365 days). All parts, including student information, contact information, findings of evaluation, and providers stamp must be completed in full or the physical will be returned to the student and this will delay the process.
8. Read and Fill out Administration of Medicine at school if necessary.

Thank you,
The Alder School Nurses
Mrs. Charlton Ext::1411
Mrs. Somers Ext:: 1410

For Office Use Only
Physical Date _____
Eligible_____
Ineligible _____

EGG HARBOR TOWNSHIP SCHOOL DISTRICT
PERMISSION FOR PARTICIPATION IN ATHLETICS

STUDENT NAME: _____MALE _____ FEMALE _____ GRADE _____

Under law, parents are required to assume responsibility for consenting to their child's participation in interscholastic athletics. Your son/daughter has made application to participate in the sport of:

_____.
(INDICATE WHICH SPORT)

Realizing that such activity involves the potential for injury, which is inherent in all sports, I/we acknowledge that even with the best coaching, the use of most advanced protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions these injuries can be so severe to result in total disability, paralysis, or even death. I/we acknowledge that I/we have read and understand this warning.

An Interscholastic Sports Insurance Policy is provided by the Board of Education. In the event of an injury please inform the health office so that insurance claim forms can be processed.

Permission is granted for _____ to participate and accompany
(PRINT STUDENT'S NAME)
the team on scheduled athletic trips.

DATE: _____ SIGNED _____
(PARENT OR GUARDIAN)

STUDENT ATHLETIC PARTICIPATION REQUEST

I hereby request permission to be enrolled in the sport of _____.

I understand that in order to participate, I must:
1. Have on file in the Health Office, a permission form signed by parent or guardian indicating approval.
2. Pass a physical given by the school physician or my own doctor.
3. Be eligible according to N.J. State Interscholastic Athletic Association Rules (student handbook, page 41).
4. Agree to obey all regulations pertaining to training rules established by the athletic department.
5. Attend faithfully to my studies and conduct myself in a sportsman-like manner at all times.
6. Be responsible for the care and safe return of all school athletic equipment issued to me.

I understand that to be eligible for any awards or letter, I must complete the entire season unless excused by the coach.

DATE:_____ STUDENT'S SIGNATURE _____

Website Resources

- Sudden Death in Athletes
  www.cardiachealth.org/sudden-death-in-athletes
- Hypertrophic Cardiomyopathy Association
  www.4hcm.org
- American Heart Association www.heart.org

Collaborating Agencies:

American Academy of Pediatrics
New Jersey Chapter
3836 Quakerbridge Road, Suite 108
Hamilton, NJ 08619
(p) 609-842-0014
(f) 609-842-0015
www.aapnj.org

American Heart Association
1 Union Street, Suite 301
Robbinsville, NJ, 08691
(p) 609-208-0020
www.heart.org

New Jersey Department of Education
PO Box 500
Trenton, NJ 08625-0500
(p) 609-292-5939
www.state.nj.us/education/

New Jersey Department of Health
P. O. Box 360
Trenton, NJ 08625-0360
(p) 609-292-7837
www.state.nj.us/health

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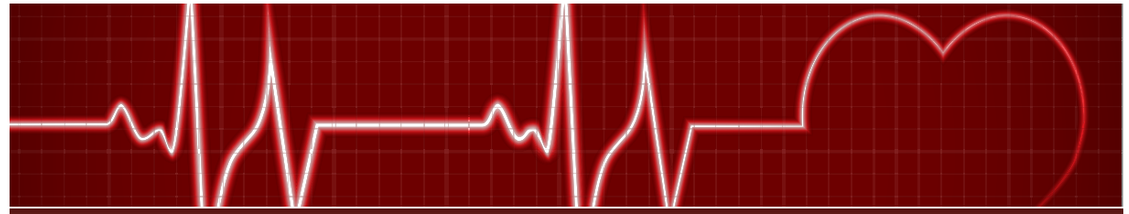
SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

The Basic Facts on Sudden Cardiac Death in Young Athletes

STATE OF NEW JERSEY
DEPARTMENT OF EDUCATION

American Heart Association
Learn and Live



SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

Sudden death in young athletes between the ages of 10 and 19 is very rare. What, if anything, can be done to prevent this kind of tragedy?

What is sudden cardiac death in the young athlete?

Sudden cardiac death is the result of an unexpected failure of proper heart function, usually (about 60% of the time) during or immediately after exercise without trauma. Since the heart stops pumping adequately, the athlete quickly collapses, loses consciousness, and ultimately dies unless normal heart rhythm is restored using an automated external defibrillator (AED).

How common is sudden death in young athletes?

Sudden cardiac death in young athletes is very rare. About 100 such deaths are reported in the United States per year. The chance of sudden death occurring to any individual high school athlete is about one in 200,000 per year.

Sudden cardiac death is more common: in males than in females; in football and basketball than in other sports; and in African-Americans than in other races and ethnic groups.

What are the most common causes?

Research suggests that the main cause is a loss of proper heart rhythm, causing the heart to quiver instead of pumping blood to the brain and body. This is called ventricular fibrillation (ven- TRICK-you-lar fib-roo-LAY-shun). The problem is usually caused by one of several cardiovascular abnormalities and electrical diseases of the heart that go unnoticed in healthy-appearing athletes.

The most common cause of sudden death in an athlete is hypertrophic cardiomyopathy (hi-per-TRO-fic CAR- dee-oh-my-OP-a-thee) also called HCM. HCM is a disease of the heart, with abnormal thickening of the heart muscle, which can cause serious heart rhythm problems and blockages to blood flow. This genetic disease runs in families and usually develops gradually over many years.

The second most likely cause is congenital (con-JEN-it-al) (i.e., present from birth) abnormalities of the coronary arteries. This means that these blood vessels are connected to the main blood vessel of the heart in an abnormal way. This differs from blockages that may occur when people get older (commonly called "coronary artery disease," which may lead to a heart attack).

Other diseases of the heart that can lead to sudden death in young people include:

- Myocarditis (my-oh-car-DIE-tis), an acute inflammation of the heart muscle (usually due to a virus).
- Dilated cardiomyopathy, an enlargement of the heart for unknown reasons.
- Long QT syndrome and other electrical abnormalities of the heart which cause abnormal fast heart rhythms that can also run in families.
- Marfan syndrome, an inherited disorder that affects heart valves, walls of major arteries, eyes and the skeleton. It is generally seen in unusually tall athletes, especially if being tall is not common in other family members.

Are there warning signs to watch for?

In more than a third of these sudden cardiac deaths, there were warning signs that were not reported or taken seriously. Warning signs are:

- Fainting, a seizure or convulsions during physical activity;
- Fainting or a seizure from emotional excitement, emotional distress or being startled;
- Dizziness or lightheadedness, especially during exertion;
- Chest pains, at rest or during exertion;
- Palpitations - awareness of the heart beating unusually (skipping, irregular or extra beats) during athletics or during cool down periods after athletic participation;
- Fatigue or tiring more quickly than peers; or
- Being unable to keep up with friends due to shortness of breath.

What are the current recommendations for screening young athletes?

New Jersey requires all school athletes to be examined by their primary care physician ("medical home") or school physician at least once per year. The New Jersey Department of Education requires use of the specific Annual Athletic Pre-Participation Physical Examination Form.

This process begins with the parents and student-athletes answering questions about symptoms during exercise (such as chest pain, dizziness, fainting, palpitations or shortness of breath); and questions about family health history.

The primary healthcare provider needs to know if any family member died suddenly during physical activity or during a seizure. They also need to know if anyone in the family under the age of 50 had an unexplained sudden death such as drowning or car accidents. This information must be provided annually for each exam because it is so essential to identify those at risk for sudden cardiac death.

The required physical exam includes measurement of blood pressure and a careful listening examination of the heart, especially for murmurs and rhythm abnormalities. If there are no warning signs reported on the health history and no abnormalities discovered on exam, no further evaluation or testing is recommended.

When should a student athlete see a heart specialist?

If the primary healthcare provider or school physician has concerns, a referral to a child heart specialist, a pediatric cardiologist, is recommended. This specialist will perform a more thorough evaluation, including an electrocardiogram (ECG), which is a graph of the electrical activity of the heart. An echocardiogram, which is an ultrasound test to allow for direct visualization of the heart structure, will likely also be done. The specialist may also order a treadmill exercise test and a monitor to enable a longer recording of the heart rhythm. None of the testing is invasive or uncomfortable.

Can sudden cardiac death be prevented just through proper screening?

A proper evaluation should find most, but not all, conditions that would cause sudden death in the athlete. This is because some diseases are difficult to uncover and may only develop later in life. Others can develop following a normal screening evaluation, such as an infection of the heart muscle from a virus.

This is why screening evaluations and a review of the family health history need to be performed on a yearly basis by the athlete's primary healthcare provider. With proper screening and evaluation, most cases can be identified and prevented.

Why have an AED on site during sporting events?

The only effective treatment for ventricular fibrillation is immediate use of an automated external defibrillator (AED). An AED can restore the heart back into a normal rhythm. An AED is also life-saving for ventricular fibrillation caused by a blow to the chest over the heart (commotio cordis).

Effective September 1, 2014, the New Jersey Department of Education requires that all public and nonpublic schools grades K through 12 shall:

- Have an AED available at every sports event (three minutes total time to reach and return with the AED);
- Have adequate personnel who are trained in AED use present at practices and games;
- Have coaches and athletic trainers trained in basic life support techniques (CPR); and
- Call 911 immediately while someone is retrieving the AED.

State of New Jersey
DEPARTMENT OF EDUCATION

Sudden Cardiac Death Pamphlet

Sign-Off Sheet

Name of School District:_____

Name of Local School: _____

I/We acknowledge that we received and reviewed the Sudden Cardiac Death in Young Athletes pamphlet.

Student Signature: _____

Parent or Guardian
Signature:_____

Date:_____

New Jersey Department of Education 2014: pursuant to the Scholastic Student-Athlet Safety Act, P.L. 2013, c71

E14-00395

2014-15 NJSIAA Banned Drugs

IT IS YOUR RESPONSIBILITY TO CHECK WITH THE APPROPRIATE OR DESIGNATED ATHLETICS STAFF BEFORE USING ANY SUBSTANCE

The NJSIAA bans the following classes of drugs:

Stimulants, Anabolic Agents, Alcohol and Beta Blockers (banned for rifle only), Diuretics and Other Masking Agents, Street Drugs, Peptide Hormones and Analogues, Anti-estrogens, Beta-2 Agonists

Note: Any substance chemically related to these classes is also banned.

THE INSTITUTION AND THE STUDENT-ATHLETE SHALL BE HELD ACCOUNTABLE FOR ALL DRUGS WITHIN THE BANNED DRUG CLASS REGARDLESS OF WHETHER THEY HAVE BEEN SPECIFICALLY IDENTIFIED.

Drugs and Procedures Subject to Restrictions

Blood Doping, Local Anesthetics (under some conditions), Manipulation of Urine Samples, Beta-2 Agonists permitted only by prescription and inhalation, Caffeine if concentrations in urine exceed 15 micrograms/ml

NJSIAA Nutritional/Dietary Supplements Warning

Before consuming any nutritional/dietary supplement product, review the product with the appropriate or designated athletics department staff!

- Dietary supplements are not well regulated and may cause a positive drug test result.
- Student-athletes have tested positive and lost their eligibility using dietary supplements.
- Many dietary supplements are contaminated with banned drugs not listed on the label.
- Any product containing a dietary supplement ingredient is taken at your own risk.

NOTE TO STUDENT-ATHLETES: THERE IS NO COMPLETE LIST OF BANNED SUBSTANCES. DO NOT RELY ON THIS LIST TO RULE OUT ANY SUPPLEMENT INGREDIENT. CHECK WITH YOUR ATHLETICS DEPARTMENT STAFF PRIOR TO USING A SUPPLEMENT.

Some Examples of NJSIAA Banned Substances in Each Drug Class

Stimulants: Amphetamine (Adderall); caffeine (guarana); cocaine; ephedrine; fenfluramine (Fen); methamphetamine; methylphenidate (Ritalin); phentermine (Phen); synephrine (bitter orange); methylhexaneamine, “bath salts” (mephedrone) etc. Exceptions: phenylephrine and pseudoephedrine are not banned.

Anabolic Agents (sometimes listed as a chemical formula, such as 3,6,17-androstenetrione) Androstenedione; boldenone; clenbuterol; DHEA (7-Keto); epi-trenbolone; etiocholanolone; methasterone; methandienone; nandrolone; norandrostenedione; stanozolol; stenbolone; testosterone; trenbolone; etc.

Alcohol and Beta Blockers (banned for rifle only) Alcohol; atenolol; metoprolol; nadolol; pindolol; propranolol; timolol; etc.

Diuretics (water pills) and Other Masking Agents: Bumetanide; chlorothiazide; furosemide; hydrochlorothiazide; probenecid; spironolactone (canrenone); triameterene; trichlormethiazide; etc.

Street Drugs: Heroin; marijuana; tetrahydrocannabinol (THC); synthetic cannabinoids (eg. spice, K2, JWH-018, JWH- 073)

Peptide Hormones and Analogues: Growth hormone(hGH); human chorionic gonadotropin (hCG); erythropoietin (EPO); etc.

Anti-Estrogens: Anastrozole; tamoxifen; formestane; 3,17-dioxo-etiochol-1,4,6-triene(ATD), etc.

Beta-2 Agonists: Bambuterol; formoterol; salbutamol; salmeterol; etc.

ANY SUBSTANCE THAT IS CHEMICALLY RELATED TO THE CLASS, EVEN IF IT IS NOT LISTED AS AN EXAMPLE, IS ALSO BANNED! IT IS YOUR RESPONSIBILITY TO CHECK WITH THE APPROPRIATE OR DESIGNATED ATHLETICS STAFF BEFORE USING ANY SUBSTANCE.

NJSIAA

1161 Route 130, P.O. Box 487, Robbinsville, NJ 08691 609-259-2776 609-259-3047-Fax

NJSIAA STEROID TESTING POLICY

CONSENT TO RANDOM TESTING

In Executive Order 72, issued December 20, 2005, Governor Richard Codey directed the New Jersey Department of Education to work in conjunction with the New Jersey State Interscholastic Athletic Association (NJSIAA) to develop and implement a program of random testing for steroids, of teams and individuals qualifying for championship games.

Beginning in the Fall, 2006 sports season, any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances on the attached page, without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition. The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing.

By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that, if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

_____	_____	_____
Signature of Student-Athlete	Print Student-Athlete's Name	Date
_____	_____	_____
Signature of Parent/Guardian	Print Parent/Guardian's Name	Date

July 1, 2008

1161 Route 130, P.O. Box 487, Robbinsville, NJ 08691 609-259-2776 609-259-3047-Fax

NJSIAA PARENT/GUARDIAN CONCUSSION POLICY ACKNOWLEDGMENT FORM

In order to help protect the student athletes of New Jersey, the NJSIAA has mandated that all athletes, parents/guardians and coaches follow the NJSIAA Concussion Policy.

A concussion is a brain injury and all brain injuries are serious. They may be caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly**. In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child/player reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:
1. Headache.
2. Nausea/vomiting.
3. Balance problems or dizziness.
4. Double vision or changes in vision.
5. Sensitivity to light or sound/noise.
6. Feeling of sluggishness or fogginess.
7. Difficulty with concentration, short-term memory, and/or confusion.
8. Irritability or agitation.
9. Depression or anxiety.
10. Sleep disturbance.

Signs observed by teammates, parents and coaches include:
1. Appears dazed, stunned, or disoriented.
2. Forgets plays or demonstrates short-term memory difficulties (e.g. is unsure of the game, score, or opponent)
3. Exhibits difficulties with balance or coordination.
4. Answers questions slowly or inaccurately.
5. Loses consciousness.
6. Demonstrates behavior or personality changes.
7. Is unable to recall events prior to or after the hit.

What can happen if my child/player keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete's safety.

If you think your child/player has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear. Close observation of the athlete should continue for several hours.

An athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time and may not return to play until the athlete is evaluated by a medical doctor or doctor of Osteopathy, trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider.

You should also inform you child's Coach, Athletic Trainer (ATC), and/or Athletic Director, if you think that your child/player may have a concussion. And when it doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:
http://www.cdc.gov/ConcussionInYouthSports/
www.nfhslearn.com

_____	_____	_____
Signature of Student-Athlete	Print Student-Athlete's Name	Date
_____	_____	_____
Signature of Parent/Guardian	Print Parent/Guardian's Name	Date

I consent to my son/daughter being tested for a base line concussion diagnostic by the High School Athletic Trainer.

_____	_____	_____
Signature of Parent/Guardian	Print Parent/Guardian's Name	Date

Please keep this form on file at the school. Do not return to the NJSIAA. Thank you.

SPORT

GRADE

EGG HARBOR TOWNSHIP SCHOOL DISTRICT

SPORTS EMERGENCY FORM

STUDENT'S NAME _____ _____ DATE OF BIRTH _____
(LAST) (FIRST) (MI) (M OR F)

ADDRESS _____ HOME PHONE _____
(STREET) (TOWN) (ZIP CODE)

FATHER _____ WORK PHONE _____ CELL PHONE _____

MOTHER _____ WORK PHONE _____ CELL PHONE_____

FATHER'S EMAIL _____MOTHER'S EMAIL _____

STUDENT RESIDES WITH: ☐ MOTHER & FATHER ☐ MOTHER ☐ FATHER ☐ GUARDIAN

OTHER (PLEASE SPECIFY) _____CUSTODY ARRANGEMENTS: ☐ YES ☐ NO

IF UNABLE TO REACH PARENT IN CASE OF EMERGENCY, CONTACT:

_____
(NAME) (ADDRESS) (PHONE #)

_____
(NAME) (ADDRESS) (PHONE #)

FAMILY PHYSICIAN_____ PHONE # _____

SIGNIFICANT HEALTH PROBLEM(S) _____ ALLERGIES _____

I hereby give my permission that in the event of an emergency _____
(PRINT STUDENT'S NAME ABOVE)
MAY be taken to the hospital for treatment. The hospital may administer emergency medical treatment if necessary.

_____ _____/_____/_____
(SIGNATURE OF PARENT OR GUARDIAN) (DATE)

NOTE: IN THE EVENT OF AN EMERGENCY THE COACH AND TRAINER WILL RELY ON THE ABOVE INFORMATION.

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any 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 with 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 if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
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 above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

■ Pre-participation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

EXAMINATION		
Height Weight	Male □	Female □
BP / (/) Pulse Vision R 20/ L 20/ Corrected □ Y □ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)b		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)_____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date_____ Signature_____

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	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 Regugitation
MVP = Mitral Valve Prolapse

■■ Preparticipation Physical Evaluation CLEARANCE FORM

EMERGENCY INFORMATION

Name _____ Sex ☐M ☐F Age _____ Date of birth _____

Allergies

_____

_____

Medications _____

_____

Immunizations_____

_____

☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for

_____

☐ Not cleared

☐ Pending further evaluation
☐ For any sports
☐ For certain sports_____

Reason _ _____

Recommendations _____

_____

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: _____

School Physician

EGG HARBOR TOWNSHIP HIGH SCHOOL
25 ALDER AVENUE
EGG HARBOR TOWNSHIP, NJ 08234

Medicine at School Information
If your child needs to take medicine during the school hours (whether over the counter or medically prescribed) the following information MUST be provided to the School Nurses' Office:

1. A note or prescription signed by your child's medical provider which includes:
    a. Diagnosis
    b. Name of Medication
    c. Dispensing instructions
2. The information may be faxed directly from the doctor to the nurses' office.
    Alder Avenue MS fax number is 609-383-1492.
3. Parents' permission to take the medication.
4. The medication must be brought to the nurse in the original container by the parent or guardian.
5. All medical information and prescriptions for medication must be updated YEARLY.

EGG HARBOR TOWNSHIP

Request for Administration of Medicine

Valid for the current school year only

Student's Name _____ Birth Date _____

Home Room _____ Grade _____

Medical Diagnosis _____

Medication _____

Dosage _____ Route _____

Time _____ Frequency _____

Side Effects _____

List other medicine child is on which may enhance, alter or impact this medication:

_____

Medication should be: _____ stored in the nurses' office _____ carried by the student_____

For Non-Emergency Medications (i.e. Inhalers, Ritalin, Adderall, etc.)

May withhold dose for field trips. School nurses ARE NOT always in attendance on field trips to administer medications and Teachers are not permitted to administer medication. YES _____NO_____

May Self-Administer inhaler for Asthma
YES NO

Comments:

_____

Physician/Health Provider's Signature Date

_____ _____

Physician/Health Provider's Name Printed Phone Number

Parent Permission to Administer Medication

Please complete the section (s) below to allow your child to receive medication while they are in school. Please note that the lower section is for self-administration of medication for asthma or potentially life-threatening illnesses **ONLY.**

I request and grant permission for the school nurse to administer medication to my child, _____ as prescribed by his/her physician as indicated on the reverse side of this form and as per the policy of Egg Harbor Township Board of Education and State **Law.** I understand that medication is to be brought to school by myself in the original prescription bottle/box labeled properly by the physician or pharmacist. I understand that I will pick up the medication at the end of the school year or at the end of its period of administration or the medication will be discarded. I understand and agree that the district shall bear no liability as a result of any injury arising from the administration of medication and I will indemnify and hold harmless the district and its employees or agents against any claims whatsoever.

_____ _____

Parent/Guardian Signature Date

_____ _____

Home Phone Number Work Phone Number

Parent Permission for Self-Administration of Medication

The Board of Education shall permit self-administration of medication for asthma or other potentially life-threatening illnesses by pupils both on school premises during regular school hours and off site or after regular school hours when a pupil is participating in field trips or extracurricular activities and the school nurse and his/her designee is not present. Life-threatening illness means an illness or condition that requires an immediate response to specific symptoms or sequel that may indicate the potential loss of life (i.e. adrenaline injection in response to anaphylaxis) See policy 5330.

My child, _____, has permission to administer his/her own medication (_____) for asthma or other potentially life-threatening illnesses both on school premises, during regular school hours and off-site or after regular school hours when they are participating in field trips or extracurricular activities and the school nurse and his/her designee is not present. I acknowledge that the Egg Harbor Township Public Schools shall incur no liability as a result of any injury arising from the self-administration of medication by my child and that I indemnify and hold harmless the District and it's employees or agents against any claims arising out of self-administration of medication by my child.

_____ _____

Parent/Guardian Signature Date

_____ _____

Home Phone Number Work Phone Number