2013-2014
Verona High School
Directions for Completing Athletic Participation Forms

All students participating in any sport including Marching Band are required to have a physical on file in the nurse's office. Your child will not be allowed to practice or compete in any sport any season unless the forms are completed and returned to the nurse's office in a timely manner**. If possible, forms should be submitted before June 21st.**
The following in the information you need to know about submitting forms:

- Physicals are only "current" and acceptable for 365 days from the exam date. The date the doctor filled out the form does not matter.
- If you child has had a physical within the last 365 days, you can have the physician complete **Part B of the NJ State Physical Examination Form** based on this exam. Please advise the doctor that **ALL AREAS OF THE FORM MUST BE COMPLETED (including vision)** or the form will be returned. Parents need to complete **Part A of the Physical Examination Form.**
- If your child had a physical within the past 365 days and you have already provided me with the forms mentioned above, your physical information is on file in the student's medical file and recorded in Genesis for the coaches viewing. If you are unsure whether your child has a current physical on file, please call me and I will check your child's medical records. If this is the case, parents need to complete the **HEALTH HISTORY UPDATE FORM.** This form is required for the 2 seasons when a new physical is not due. You will receive a confirmation that the school doctor has approved your son/daughter's physical.
- If your child's physical is due after the deadline listed below but before the first athletic practice, please speak with Mrs. Bush directly. 973-571-6750 ext 1014
- Physicals that are current on the first day of practice are good for the season. **You are strongly encouraged to get your child a new physical and submit the forms immediately.**
- The **NJ State Physical Form is the only acceptable form according to NJ STATE LAW.**
- All forms are attached to this email. The information and all forms are also available on the website, either under athletics or on Mrs. Bush's webpage.
- State law further mandates that the school physician countersign every physical done by a private doctor. It is imperative that physicals be received by the deadlines listed below so that there is no delay in your child being able to participate.
- Forms that are not submitted by the last day of school may be brought to the main office of the high school during regular summer hours. You will be asked to sign that you have dropped off these papers. The school nurse works limited hours during the summer months.
- **Steroid** and **concussion** forms are returned directly to the Coach.

Fall season 2013: Parts A &B or Health History Update due by **Friday, July 26th. Football practice begin Monday, August 19th. Other sports and band camp follow.**
Winter season 2013-14: Part A & B or Health History Update due by **Friday, November 1.** Practices begin **Thursday, November 14** for Swimming and Hockey. **Monday, December 2** for remaining winter sports.
Spring season 2014: Physical due **Friday, February 7**. Practices begin **Monday, March 2nd.**

Failure to adhere the above dates and requirements may result in your son/daughter missing the first practices.

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 **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:
       - ☐ Rash ☐ Hives ☐ 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):

_____
_____
_____
_____
_____

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):

_____

_____

_____

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):

_____

_____

_____

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):

_____

_____

_____

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):

_____

_____

_____

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):

_____

_____

_____

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:

_____
_____
_____

Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Additional observations:

_____
_____
_____
_____

General Diagnosis: _____
_____
_____

General Recommendations:

_____
_____

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

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

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

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: _____

_____

Verona Public Schools
HEALTH *UPDATE* FORM
FOR ATHLETIC PARTICIPATION

Parent/Guardian complete this form ***less than 60 days*** before the below listed deadlines.

"To participate on a school athletic squad or team, each candidate whose medical examination was completed more than 60 days prior to the first practice session shall provide a health history update of medical problems experienced since the last medical examination. This shall be completed and signed by the parent/guardian." ***Please return Health Update Form to the Nurse.***

STUDENT'S NAME: _____ Birth date: _____ Grade: ____
Date of last sports physical: _____ Sport trying out for: _____

SINCE **your child's "Annual Athletic Pre-Participation Physical Evaluation" was completed, has he/she experienced any of the following *CHANGES*:**

***Explain in full including dates, any "YES" answers**

1. HOSPITALIZATION/OPERATIONS YES* NO
_____

2. ILLNESSES YES* NO
_____

3. INJURIES YES* NO
_____

4. CARE ADMINISTERED BY A PHYSICIAN, ADVANCED PRACTICE NURSE OR PHYSICIAN'S ASSISTANT YES* NO
_____

5. MEDICATIONS YES* NO
_____

6. ALLERGIES YES NO
_____

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

**** ANY CHANGES IN STATUS MUST BE REVIEWED BY THE SCHOOL PHYSICIAN AND YOUR MEDICAL PROVIDER and may require a note from your physician stating that your child is "Cleared for Sports." Return this form to the school nurse by the below DEADLINES:***

Sports Season	**2013-2014**
Fall	
Football, Volleyball, Soccer, Cross Country, Cheering, Girl's Tennis	July 26, 2013
Winter	
Wrestling, Indoor Track, Swimming, Ice Hockey, Cheering, Basketball	November 1, 2013
Spring	
Baseball, Softball, Lacrosse, Track, Boy's Tennis, Golf	February 7, 2014

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 ware 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

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

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

May 1, 2009