To: Elmwood Park High School Parents and Athletes

From: Mr. Basile, Athletic Director
Mrs. LaBianco, Athletic Trainer

Re: ATHLETIC PHYSICAL FORMS

The information below will assist in the completion of the pre-participation paperwork that is necessary for all physical activities. This is the first step in medical clearance and must be submitted by the announced due date in order to be considered for participation.

The NJSIAA requires yearly physical examinations which must be completed on the attached forms. Universal forms will not be accepted. When completing the forms, please follow the following guidelines:

- All parent and student signature lines are completed.
- All medical history questions must be answered completely and accurately. If any questions are answered "yes", provide an answer/explanation.
- If your son/daughter uses an inhaler for asthma, a CURRENT (same school year) asthma treatment plan MUST be on file with the school nurse.
- If your son/daughter has an allergy that requires an Epi-pen, a CURRENT (same school year) allergy treatment plan MUST be on file with the school nurse, along with the medication.
- The doctor's signature is required on the Cardiac Module line. If your doctor is not in New Jersey, he/she may choose not sign that portion. If that occurs, the paperwork will be returned.

In addition to the physical paperwork, the NJSIAA requires parents **AND** student-athletes to review information on the following topics and provide acknowledgement of receipt and review.

- Concussion Education and Policy
- Eye Glasses and Sports Safety Fact Sheet
- Opioid Abuse Fact Sheet
- Sudden Cardiac Death Education
- Steroid/Banned Substance Testing

This information can be found on to the high school athletic webpage under the physical packets tab or by using the following link: **https://www.elmwoodparkschools.org/domain/125**

Information on our injury policies, concussion baseline testing and protocol, school insurance information, and information on purchasing extra accidental insurance for your child can be found by clicking on the athletic training tab under athletics or by using the following link:
https://sites.google.com/epps.org/elmwoodparkathletictraining/home?authuser=0

Please read through all documents and sign the attached form acknowledging you have done so, and return by the due date to Mrs. LaBianco. **NO PAPERWORK WILL BE ACCEPTED AFTER THE DUE DATE**. If you have any questions regarding this process, please contact Mrs. LaBianco at labianco@epps.org.

ELMWOOD PARK SCHOOL DISTRICT

INTERSCHOLASTIC ATHLETIC PERMISSION FORM

Student's Name: ____

Grade: ____________________ School Year: ____________________ Sport: __________________________

I. Consent of Parent/ Guardian

I hereby give my consent for my child to participate in interscholastic athletics in the Elmwood Park School District for the current school year.

I acknowledge that participation in athletics involves an inherent potential for injury. Although the staff members exercise every precaution against possible injury, parent or guardians are required to assume responsibility for consenting to participation and to risk the liability of injury. I acknowledge that physicals hazards may be encountered in the conduct of activity and in all arrangements incidental thereto.

I hereby authorize the release of my child's pertinent medical information to appropriate professional staff. I give consent and understand that the information may be shared, when necessary, with appropriate professional staff involved in the care of my child.

In the event that my child is injured while participating in athletics, I hereby grant permission for my child to receive treatment by the appropriate medical staff member or at a duly licensed and certified hospital or medical facility. I understand that emergency medical transportation would not take place until a reasonable effort has been made to contact me.

The Elmwood Park Board of Education provides excess coverage insurance for all student athletes. Such excess coverage generally provides for coverage beyond the initial coverage provided by the student's family home, private, or business insurance.

I am advised that student-athletes are held responsible for the athletic equipment and uniforms owned and issued to them by the school district. Also, I am advised that student athletes are to adhere to the Elmwood Park Board of Education Student/Athletic Conduct and Responsibilities Policy.

II. Transfer Students/Foreign Exchange Students

If the athlete attended a high school (9-12th grades) other than Elmwood Park High School in the preceding school year, please list the name of the school, city, and state below:

____

III. Eligibility

I am advised that in order to participate in games or practices the student must meet all terms of medical and academic eligibility. A completed medical history and physical examination must be completed and which must then be granted final approval by the school physician.

Signature of Parent/Guardian: ____ Date: ______________

Signature of Student: ____ Date: ______________

NJSIAA Concussion Policy Acknowledgement Form/Baseline Test Consent

By signing below, you acknowledge that you have received and reviewed the "Concussion Fact Sheet" and that you understand the policy/procedures for a student with a suspected concussion. You understand that the student-athlete will not be allowed to return to competition or practice until he/she has written clearance from a physician trained in concussion management and has completed his/her return-to-play protocol.

By signing below you are also giving permission for your son/daughter to participate in concussion baseline testing.

______________________________	______________________________
Student-Athlete Name	Student-Athlete Signature
______________________________	______________________________
Parent/Guardian Name	Parent/Guardian Signature

Sudden Cardiac Arrest Information Sheet & Acknowledgement of Receipt and Review Form

The Commissioner of Education in NJ, in consultation with the Commissioner of Health in NJ, the American Heart Association, and the American Academy of Pediatrics, have developed a pamphlet that provides information about Sudden Cardiac Death.

By signing below, you acknowledge that you have received and reviewed the "Sudden Cardiac Death in Young Athletes" pamphlet.

______________________________	______________________________
Student-Athlete Name	Student-Athlete Signature
______________________________	______________________________
Parent/Guardian Name	Parent/Guardian Signature

Opioid Use and Misuse Educational Fact Sheet

By signing below, you acknowledge that you have received and reviewed the "Opioid Use and Misuse Educational Fact Sheet".

______________________________	______________________________
Student-Athlete Name	Student-Athlete Signature
______________________________	______________________________
Parent/Guardian Name	Parent/Guardian Signature

NJSIAA Banned Substance Testing Policy & Consent to Random Testing

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

______________________________	______________________________
Student-Athlete Name	Student-Athlete Signature
______________________________	______________________________
Parent/Guardian Name	Parent/Guardian Signature

School Insurance Policy

By signing below, you are stating that you decline the offer to purchase extra accidental injury insurance for your child and you understand that the school insurance will NOT cover all medical bills. The school is NOT responsible for any bills that may occur as a result of a sports injury.

______________________________	______________________________
Student-Athlete Name	Student-Athlete Signature
______________________________	______________________________
Parent/Guardian Name	Parent/Guardian Signature

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

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 ____________

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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 ____________

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NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

■ Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

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 [a] • 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		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ 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 ______________________________

____

I have examined the above-named student and completed the preparticipation 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, a 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 of exam ____________

Address ______________________________ Phone ______________

Signature of physician, APN, PA ______________________________

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PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name ____________________ Sex ☐ M ☐ F Age __________ Date of birth __________

☐ 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 ____________________

EMERGENCY INFORMATION

Allergies ____________________

Other information ____________________

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on ____________________
(Date)

Approved ______ Not Approved ______

Signature: ____________________

I have examined the above-named student and completed the preparticipation 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) ____________________ Date __________

Address ____________________ Phone __________

Signature of physician, APN, PA ____________________

Completed Cardiac Assessment Professional Development Module

Date __________ Signature ____________________

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ELMWOOD PARK SCHOOL DISTRICT

MEDICAL TREATMENT CONSENT
EMERGENCY CONTACT FORM

Student Name: ____ Sport/Activity:_______________________

In the event of a medical emergency, I hereby grant permission for my child to receive emergency medical transportation to and treatment at a duly licensed and certified hospital or medical facility.

____ ______________________________

Signature of Parent/Legal Guardian Date

Doctor's Name:____ Phone Number:_____________________

Hospital of Preference: ____

EMERGENCY CONTACT INFORMATION

Mother/Guardian's Name:____

Phone Number(s):____

Father/Guardian's Name:____

Phone Number(s):____

In the event that you cannot be reached, please provide us with a parental substitute:

Parental Substitute Name: __________________________________ Phone Number(s): __________________

PLEASE PROVIDE THE FOLLOWING MEDICAL INFORMATION:

1. Does your child have a history of any of the following conditions (please check):

   _____Heart Condition _______Diabetes ________ Epilepsy ______Asthma

2. Is your son/daughter currently taking any medication?

   ______YES ____ NO Please List:____

3. Does your son/daughter have any allergies (food, medication, bee stings, other)?

   ______YES ____ NO Please List:____