

KINGWOOD TOWNSHIP SCHOOL

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.

KINGWOOD TOWNSHIP SCHOOL

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

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

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: _____

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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: _____

Sports-Related Concussion and Head Injury Fact Sheet and Parent/Guardian Acknowledgement Form

A concussion is a brain injury that can be caused by a blow to the head or body that disrupts normal functioning of the brain. Concussions are a type of Traumatic Brain Injury (TBI), which can range from mild to severe and can disrupt the way the brain normally functions. Concussions can cause significant and sustained neuropsychological impairment affecting problem solving, planning, memory, attention, concentration, and behavior.

The Centers for Disease Control and Prevention estimates that 300,000 concussions are sustained during sports related activities nationwide, and more than 62,000 concussions are sustained each year in high school contact sports. Second-impact syndrome occurs when a person sustains a second concussion while still experiencing symptoms of a previous concussion. It can lead to severe impairment and even death of the victim.

Legislation (P.L. 2010, Chapter 94) signed on December 7, 2010, mandated measures to be taken in order to ensure the safety of K-12 student-athletes involved in interscholastic sports in New Jersey. It is imperative that athletes, coaches, and parent/guardians are educated about the nature and treatment of sports related concussions and other head injuries. The legislation states that:

- All Coaches, Athletic Trainers, School Nurses, and School/Team Physicians shall complete an Interscholastic Head Injury Safety Training Program by the 2011-2012 school year.
- All school districts, charter, and non-public schools that participate in interscholastic sports will distribute annually this educational fact to all student athletes and obtain a signed acknowledgement from each parent/guardian and student-athlete.
- Each school district, charter, and non-public school shall develop a written policy describing the prevention and treatment of sports-related concussion and other head injuries sustained by interscholastic student-athletes.
- Any student-athlete who participates in an interscholastic sports program and is suspected of sustaining a concussion will be immediately removed from competition or practice. 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 treatment and has completed his/her district's graduated return-to-play protocol.

Quick Facts

- Most concussions do not involve loss of consciousness
- You can sustain a concussion even if you do not hit your head
- A blow elsewhere on the body can transmit an "impulsive" force to the brain and cause a concussion

Signs of Concussions (Observed by Coach, Athletic Trainer, Parent/Guardian)

- Appears dazed or stunned
- Forgets plays or demonstrates short term memory difficulties (e.g. unsure of game, opponent)
- Exhibits difficulties with balance, coordination, concentration, and attention
- Answers questions slowly or inaccurately
- Demonstrates behavior or personality changes
- Is unable to recall events prior to or after the hit or fall

Symptoms of Concussion (Reported by Student-Athlete)

- Headache
- Nausea/vomiting
- Balance problems or dizziness
- Double vision or changes in vision
- Sensitivity to light/sound
- Feeling of sluggishness or fogginess
- Difficulty with concentration, short term memory, and/or confusion

What Should a Student-Athlete do if they think they have a concussion?

- **Don't hide it.** Tell your Athletic Trainer, Coach, School Nurse, or Parent/Guardian.
- **Report it.** Don't return to competition or practice with symptoms of a concussion or head injury. The sooner you report it, the sooner you may return-to-play.
- **Take time to recover.** If you have a concussion your brain needs time to heal. While your brain is healing you are much more likely to sustain a second concussion. Repeat concussions can cause permanent brain injury.

What can happen if a student-athlete continues to play with a concussion or returns to play too soon?

- Continuing to play with the signs and symptoms of a concussion leaves the student-athlete vulnerable to second impact syndrome.
- Second impact syndrome is when a student-athlete sustains a second concussion while still having symptoms from a previous concussion or head injury.
- Second impact syndrome can lead to severe impairment and even death in extreme cases.

Should there be any temporary academic accommodations made for Student-Athletes who have suffered a concussion?

- To recover cognitive rest is just as important as physical rest. Reading, texting, testing-even watching movies can slow down a student-athletes recovery.
- Stay home from school with minimal mental and social stimulation until all symptoms have resolved.
- Students may need to take rest breaks, spend fewer hours at school, be given extra time to complete assignments, as well as being offered other instructional strategies and classroom accommodations.

Student-Athletes who have sustained a concussion should complete a graduated return-to-play before they may resume competition or practice, according to the following protocol:

- **Step 1:** Completion of a full day of normal cognitive activities (school day, studying for tests, watching practice, interacting with peers) without reemergence of any signs or symptoms. If no return of symptoms, next day advance.
- **Step 2:** Light Aerobic exercise, which includes walking, swimming, and stationary cycling, keeping the intensity below 70% maximum heart rate. No resistance training. The objective of this step is increased heart rate.
- **Step 3:** Sport-specific exercise including skating, and/or running; no head impact activities. The objective of this step is to add movement.
- **Step 4:** Non contact training drills (e.g. passing drills). Student-athlete may initiate resistance training.
- **Step 5:** Following medical clearance (consultation between school health care personnel and student-athlete's physician), participation in normal training activities. The objective of this step is to restore confidence and assess functional skills by coaching and medical staff.
- **Step 6:** Return to play involving normal exertion or game activity.

For further information on Sports-Related Concussions and other Head Injuries, please visit:

www.cdc.gov/concussion/sports/index.html

www.nfhs.com

www.ncaa.org/health-safety

www.bianj.org

www.atsnj.org

Signature of Student-Athlete

Print Student-Athlete's Name

Date
