Preparticipation Physical Evaluation

HISTORY FORM

Best contact phone # ________________________________

(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.)

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:

<table>
<thead>
<tr>
<th>Medicines</th>
<th>Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have any allergies?  □ Yes  □ No  If yes, please identify specific allergy below.

<table>
<thead>
<tr>
<th>Medicines</th>
<th>Pollens</th>
<th>Food</th>
<th>Stinging Insects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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


BONE AND JOINT QUESTIONS

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 or anyone in your family have sickle cell trait or disease?

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?

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?

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

Signature of athlete   ____________________________ Date _____________________

Signature of parent/guardian   ____________________________ Date _____________________
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

<table>
<thead>
<tr>
<th>Sports interested in playing</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enlarged spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteopenia or osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spina bifida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex allergy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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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### 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?
   - 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

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
<th>BP</th>
<th>( )</th>
<th>Pulse</th>
<th>Vision R 20'/ L 20'/ Corrected</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

**MEDICAL**

<table>
<thead>
<tr>
<th>Appearance</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 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 & Respiratory | | |

| Abdomen | | |

| Genitourinary (males only) | | |
| HSV, lesions suggestive of MRSA, tinea corporis | | |

| Skin | | |

| 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 | | |

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
†Consider GI exam if in private setting. Having third party present is recommended.
‡Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Clearance for all sports without restriction
- Clearance for all sports without restriction with recommendations for further evaluation or treatment for

| Reason | | |

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 __________________________

Address __________________________ Phone __________________________

Signature of physician, APN, PA __________________________
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 ______________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

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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