BLACK HORSE PIKE REGIONAL SCHOOL DISTRICT

Triton • Highland • Timber Creek

Please be sure to complete the following checklist in its entirety, otherwise this athletic physical packet will not be considered "complete" and ready for review by the school physician and/or school nurse:

- ❑ **Athletic Registration Instructions** - Sports Participation forms will now be completed through Parent Access just as you have done in the past with other school related forms. Please log into your Parent Access account at https://parents.bhprsd.org/genesis Once logged in, you will see the Sports Participation form to complete. You must be logged in as a Parent account.

  **** Student accounts will not have access to the form ****

  If you do not remember your password, you can use the "forgot my password" function. Your username is the email address we have on file. Only click it once. Please be aware that the password reset could take some time, up to 24 hours. If you still do not receive an email, you may be using the wrong email address. Try a different one or contact the counseling office for the email you have on file.

- ❑ **ImPACT Test** – Computerized baseline concussion testing. Required test to be completed by ALL athletes and shall be valid for 2 years from the date of initial testing.

- ❑ **Physical Evaluation History Form** – this form is 2 pages and should be completed by the parent/guardian. Page 2 is only to be completed if the athlete has special needs.

- ❑ **Physical Examination Form** – this form is also 2 pages and must be completed by the athlete's family physician. ***IT IS IMPERATIVE THAT ALONG WITH THE PHYSICIAN 'S SIGNATURE & STAMP ON PAGE 1 OF THIS FORM, THAT THE PHYSICIAN ALSO SIGNS AND ACKNOWLEDGES THE "C ARDIAC ASSESSMENT PROFESSIONAL MODULE" AT THE BOTTOM OF PAGE 2 OF THIS FORM***

- ❑ **Medication Dispensing Form** – this form shall be completed if the athlete is prescribed an inhaler or epi-pen, and must be completed by the parent/guardian and family physician.

- ❑ **ALL PHYSICAL FORMS MUST BE TURNED INTO THE SCHOOL NURSE OR THE MAIN OFFICE ONLY.**

*Please be aware that completing the registration process and physician's physical exam does NOT guarantee the athlete's eligibility. Eligibility is contingent upon:

- ✓ Completed physical packet paperwork
- ✓ A valid physical (good for 365 days)
- ✓ Academic requirements/credits
- ✓ Behavioral/conduct requirements
- ✓ No outstanding fines

Black Horse Pike Regional School District

580 Erial Road, Blackwood, NJ 08012

ImPACT

All athletes must complete baseline ImPACT testing before being allowed to participate in their sport. ImPACT is a computerized concussion evaluation system that measures verbal and visual memory, processing speed and reaction time. To most effectively care for athletes who have sustained concussions, it is helpful to compare baseline data to post-concussion data so that any deficits can be determined and proper return-to-play decisions can be made.

INSTRUCTIONS FOR ATHLETES

Please understand that you cannot "fail" this test. It is extremely important, however, that you:

1. Set aside 30 minutes in a quiet place with **NO DISTRACTIONS**.
2. **READ** the instructions very carefully. Failure to do this can affect the test results and you may then have to re-take the test.
3. If you do not have Internet access at home and are unable to take the test anywhere else, please contact your certified athletic trainer.

TO TAKE TO THE TEST:

1. Go to Internet Explorer or other web browser
2. Type in the website: www.impacttestonline.com/schools/
3. Select "New Jersey"
4. Launch baseline test
5. Follow the directions. Make sure to read all instructions!

TCHS Customer ID Code: 542D7DC4DA
HHS Customer ID Code: ADDB273F4E
THS Customer ID Code: 44907883D4

ANY QUESTIONS OR CONCERNS SHOULD BE DIRECTED TO YOUR SCHOOL'S CERTIFIED ATHLETIC TRAINER LISTED BELOW.

Highland Regional High School
Athena DeAngelis
(856) 227-4100, ext. 4100
adeangelis@bhprsd.org

Timber Creek Regional High School
Dominic Acchitelli
(856) 232-9703, ext. 6050
dacchitelli@bhprsd.org

Triton Regional High School
Rachel Pantaleo
(856) 939-4500, ext. 2078
rpantaleo@bhprsd.org

PARENT/GUARDIAN FORM

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 _____

PARENT/GUARDIAN FORM

ONLY use this form for disablities.
DO NOT use for injuries.

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

PHYSICIAN FORM

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).

Physician/Provider's Stamp

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)†		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic‡		
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 GU exam if in private setting. Having third party present is recommended.
‡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 _____

Address _____ Phone _____

Signature of physician, APN, PA _____

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

PHYSICIAN FORM

Preparticipation Physical Evaluation
CLEARANCE FORM

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

O Cleared for all sports without restriction

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

_____

O Not cleared

O Pending further evaluation

O For any sports

O 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 _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

This page is to be completed by Parent/Guardian and Physician

Form 4

Black Horse Pike Regional School District -Medication – Dispensing Form

List only one medication on a form, additional forms available upon request.

Parent

PARENTS SHOULD FILL OUT THE BOLDED AREAS

I request the enclosed medication, in the original container, to be administered to my child and shall release school personnel from all liability. I give the School Nurse permission to contact the physician and/or pharmacist with any question concerning the medication.

Name of Child _____

Name & Strength of Medication _____

Dosage _____

Signature of Parent/Guardian X _____

INHALER AND EPI-PEN PATIENTS ONLY

In case of ASTHMA or potentially life threatening illness, will the student be giving himself/herself this medication?

☐ **Yes** ☐ **No** **If yes, please sign below**

We the parents or guardians of the pupil, acknowledge that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and that we shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the self-administration of medication by the pupil. The permission is effective for the school year for which it is granted.

Signature of Parent/Guardian X _____ **Date** _____

Both sections must have completed information and required signatures.

Doctor

DOCTORS MUST COMPLETE ALL BOLDED INFORMATION

Students Name _____ **Age** ____ **Grade** ____ **School** _____

Name & Strength of Medication _____ **Dosage** _____

Time & Route of Administration in School _____

Reason for Medication _____

Effective Dates: from _____ **to** _____

Most common side effects: _____

It is my understanding the School Nurse charged with the administration of medication may rely upon my direction as contained in this document. I further certify that I am the physician who prescribed the medication and that the student named above is under my supervision as a patient for diagnosis and treatment. Any alteration to the above will occur only with written directions from the attending physician.

_____ **Doctor's Name (Print)**

X _____ **Doctor's Signature**

_____ **Patient's Medication Allergies**

_____ **Doctor's Address**

_____ **Date**

_____ **Doctor's Telephone Number**

INHALER AND EPI-PEN PATIENTS ONLY

I certify that the pupil has asthma or another life threatening illness and is capable of, and has been instructed in, the proper method of self-administration of medication.

In case of ASTHMA or potentially life threatening illness, will the student be giving himself/herself this medication?

☐ **Yes** ☐ **No** ***X*** _____

Doctor's Signature REQUIRED