

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:

- www.FamilyID.com** – Online athletic participation registration. This registration **MUST** be completed by **ALL** athletes and done so for **EVERY** season, **EVERY** school year. Student-athlete eligibility will **NOT** be verified without the completion of this process.
- 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 “CARDIAC 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 online 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

Family ID Registration

FamilyID is a secure registration platform that provides you with an easy, user-friendly way to register for our athletic program, and helps us to be more administratively efficient and environmentally responsible. When you register through FamilyID, the system keeps track of your information in your FamilyID profile so you enter your information only once for multiple uses, multiple family members and multiple sports programs.

It will be helpful to have the following information handy to allow for accurate completion of your online registration.

- Doctor information; health insurance information; emergency contact information

A parent/guardian should register by going to: <https://www.familyid.com/black-horse-pike-regional-school-district>. Directions can be found in the “Links” section located on the right side of the FamilyID/Black Horse Pike home page.

If you need assistance with you registration, you can call Family ID at 888-800-5583 x1 or email support@familyid.com. FamilyID also offers online chat during business hours and a support center.

FamilyID registration MUST be done completed by ALL athletes for EVERY season. Registrations do not carry over from sport to sport



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

■ 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	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: ... Asthma ... Anemia ... Diabetes ... Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
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: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
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)?			40. Have you ever become ill while exercising in the heat?		
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?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
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)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			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 _____

**ONLY use this form for disabilities.
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 _____

■ 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 ^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			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
^bConsider GU exam if in private setting. Having third party present is recommended.
^cConsider 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 _____ @@@@@@@@

■ 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, "1/, 1" _____ @

@@@@@@@_

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

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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.

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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
DYes **D**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.

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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) _____ Doctor's Signature X _____

Parent'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(
DYes **D**No X _____

Doctor's Signature REQUIRED