Central Registration Office

331 Lev is Drive
Mount Holly, NJ 08060

Mrs. Charisse Jones

Central Registrar

NEW STUDENT REGISTRATION
F.W. HOLBEIN MIDDLE SCHOOL
GRADES 5th - 8th

Go to our website www.mtholly.k12.nj.us & click on Central Registration Page & Pre-Register your Student/s

Please complete and bring with you the attached forms along with the listed documents below

- You will bring completed packet forms with you to your scheduled appointment

Documents to bring in with your registration packet:

1. Original Birth Certificate

2. Proof of residency (Deed or mortgage statement, tax bill, lease (if you rent)
   Please provide 2 documents from the list below:
   - utility bills, Cable, phone, electric etc.
   - Voter registration, licenses, permits, bank statement etc.
   - Documents issues by a governmental entity

3. Up to Date Immunization Records

4. Physical Examination Record

5. Transfer Card from last school attended

6. Last Report Card

7. Achievement Test Scores

8. Child Study Team Documents (if applies)

PLEASE NOTE: YOUR CHILD WILL NOT BE FULLY REGISTERED UNTIL YOU COMPLETE ALL STEPS AS INDICATED ABOVE.

Phone: 609-267-7108 **Fax:** 609-702-9082 Email: cjones@mtholly.k12.nj.us

Student Registration Questionnaire

School Year _____

Date: _____

Student Name: _____

Please answer the following questions relating to prior/present schooling:

1. Please list the name and address of the most recent school your child attended.

   _____

   _____

2. Does your child have an IEP for Special Education? _____ Or a 504 Plan? _____
3. Has your child ever been retained in school? _____ If so, what grade level(s)? _____
4. Has your child previously attended Mount Holly Township School District? _____
5. If applicable, please list any siblings that are enrolled in Mount Holly Township Schools:

   _____

   _____

For children born in another country outside of the United States, please answer the following:

IF your child was born outside of the United States, what was his/her first date of entry into the US? _____
AND what was your child's first date he/she was enrolled in school in the US? _____

Please answer the following questions relating to residency:

1. Who has primary custody of your child? (check one) Both Mom and Dad _____ Mom_____ Dad_____

   Other (please list relationship) _____
   If other, you must provide custody documents
2. Do you own your home? _____
3. Do you rent? _____
4. Are you living temporarily with family or friends? _____ If yes, you will need to complete a residency affidavit.

_____ _____

Printed name of Parent or Guardian **Signature of Parent or Guardian**

Mount Holly Township School District
331 Levis Drive, Mount Holly, NJ 08060
STUDENT REGISTRATION PACKET

Date

Name of Person Enrolling Student

Relationship to Student

Primary Language(s) you Speak

STUDENT RESIDENCE INFORMATION

Student Name (First, Middle, Last)

Street Address/Apt #

City, State, Zip

How long has student lived at this address? Years Months

Does the student reside in any other residence? Yes ☐ No ☐

If yes, please list other address.

When does the student reside there?

Do you have any present intention of moving from this/these address(es)? Yes ☐ No ☐

If yes, when do you plan to move?

Where do you plan to move?

Domicile is the place where a person lives in his or her fixed, permanent home. This home must be the place to which he or she intends to return when he or she goes away, and from which he or she has no intention of moving. A person can have only one "domicile" at a time, even if he or she may have more than one residence.

I hereby swear that the student is domiciled within the Mt. Holly Township School District, and I will assume all personal obligations for the student relative to school requirements.

I further understand that falsifying residence information will result in my financial responsibility for district expenses up to and including tuition calculated for each day of the student's ineligible attendance within the district based on an annual tuition rate determined by the district.

Printed Name Date

_____

Signature

STUDENT REGISTRATION PACKET

STUDENT PERSONAL INFORMATION

Date of Birth

Current Age of Student

Gender

Birth City

Birth State

Birth Country

Primary Language Spoken in Student's Home

Ethnicity Select If other, please specify

Is this Student in Need of Child Study Team Services? Yes ☐ No ☐

Yes If yes, please explain

Has this student attended school outside of the U.S.? Yes ☐ No ☐

If yes, when did the student first attend a school in the U.S.

Has this student ever previously attended school in the Mount Holly Twp. School District? Yes ☐ No ☐

If yes, what school? Select One

Grades Attended

Years Attended

Has this student ever attended school in any other school District? Yes ☐ No ☐

If yes, what school?

Grades Attended

Years Attended

STUDENT REGISTRATION PACKET

STUDENT SIBLING(S) Please list all Name

Name (First, Middle, Last)

Address (Number, Street, City, State, Zip)

Date of Birth

Name (First, Middle, Last)

Address (Number, Street, City, State, Zip)

Date of Birth

Name (First, Middle, Last)

Address (Number, Street, City, State, Zip)

Date of Birth

Name (First, Middle, Last)

Address (Number, Street, City, State, Zip)

Date of Birth

Name (First, Middle, Last)

Address (Number, Street, City, State, Zip)

Date of Birth

STUDENT REGISTRATION PACKET

MOTHER OF STUDENT

Name (First, Middle, Last)

Address/Apt. #

City, State, Zip

Email Address

Home Phone Is this the preferred number? Yes ☐ No ☐

Cell Phone Is this the preferred number? Yes ☐ No ☐

Date of Birth

Place of Birth

If deceased, what year?

FATHER OF STUDENT

Name (First, Middle, Last)

Address/Apt. #

City, State, Zip

Email Address

Home Phone Is this the preferred number? Yes ☐ No ☐

Cell Phone Is this the preferred number? Yes ☐ No ☐

Date of Birth

Place of Birth

If deceased, what year?

STUDENT REGISTRATION PACKET

LEGAL GUARDIAN OF STUDENT, (If applicable)

Name (First, Middle, Last)

Address/Apt. #

City, State, Zip

Email Address

Home Phone Is this the preferred number? Yes ☐ No ☐

Cell Phone Is this the preferred number? Yes ☐ No ☐

Date of Birth

Place of Birth

If deceased, what year?

PARENTS/LEGAL GUARDIANS/OTHER PERSON HAVING CUSTODY AND CONTROL OF STUDENT INFORMATION

Who has legal custody of the student? Select One

If other, please explain

Does the student reside with an adult other than the parent? Yes ☐ No ☐

If yes, please explain

Does that person have legal control of the student, either through a custody order or legal guardianship?

Yes ☐ No ☐

(All legal guardians are required to provide original court credentials from a United States Court with the original court seal and signature of a Judge.)

STUDENT REGISTRATION PACKET

EMERGENCY CONTACT #1 (Not parent)

Name

Address

Home Phone

Cell Phone

Relationship to Student

Send Mail Yes ☐ No ☐
Send Call Out Yes ☐ No ☐
Allow Portal Access Yes ☐ No ☐

EMERGENCY CONTACT #2 (Not parent)

Name

Address

Home Phone

Cell Phone

Relationship to Student

Send Mail Yes ☐ No ☐
Send Call Out Yes ☐ No ☐
Allow Portal Access Yes ☐ No ☐

EMERGENCY CONTACT #3 (Not parent)

Name

Address

Home Phone

Cell Phone

Relationship to Student

Send Mail Yes ☐ No ☐
Send Call Out Yes ☐ No ☐
Allow Portal Access Yes ☐ No ☐

EMERGENCY CONTACT #4 (Not parent)

Name

Address

Home Phone

Cell Phone

Relationship to Student

Send Mail Yes ☐ No ☐
Send Call Out Yes ☐ No ☐
Allow Portal Access Yes ☐ No ☐

NEW JERSEY DATA COLLECTION INFORMATION

Do you have health insurance Yes ☐ No ☐

If yes, please list insurance provider:

If no, NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information, visit www.njfamilycare.org to apply online or call 1-800-701-0710.

You may release my name and address to the NJFamilyCare Program to contact me about health insurance Yes ☐ No ☐

All information I provided on these pages is tru and correct to the best of my knowledge. There is no deliberate omission, concealment, or falsification of relevant facts.

Printed Name Date

_____

Signature

Sworn and subscribed to me on

this _____ day of _____, 20____

_____

Signature of Notary Public
Affix Stamp Here

MOUNT HOLLY TOWNSHIP PUBLIC SCHOOLS

Central Registration Office
331 Levis Drive, Mount Holly, NJ 08060

Mrs. Charisse Jones, Central Registrar Tel: (609) 267- 7108

Date:

To:

Fax:

Phone:

The following student has registered into the Mount Holly Township Public School District.

STUDENT'S NAME	GRADE	DATE OF BIRTH

Please forward all academic and health records, standardized test scores as soon as possible to:

John Bralnerd School
100 Wollner Drive Mount
Holly, NJ 08060 Phone:
(609) 267- 3600
Fax: (609) 702-0569
cjones@mtholly.k12.nj.us

Gertrude C. Folwell School
455 Jacksonville Road
Mount Holly, NJ 08060
Phone: (609) 267- 0071
Fax: (609) 267-0062
cjones@mtholly.k12.nj.us

F. W. Holbein Middle
School 333 Levis Drive
Mount Holly, NJ 08060
Phone: (609) 267- 7200
Fax: (609) 702-9775
cjones@mtholly.k12.nj.us

All Special Education Records Mailed to:
CST Office
331 Levis Drive
Mount Holly, NJ 08060
Phone: (609) 267-7108
Fax: (609) 702-9082
tlasala@mtholly.k12.nj.us

I,_____, do hereby request the release of all school records to Mount Holly Township Public Schools. I hereby attest that I have legal authority to request the release of these records.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Printed Name of Parent / Guardian Relationship to Student

MOUNT HOLLY TOWNSHIP SCHOOLS
MOUNT HOLLY, NEW JERSEY

CENTRAL REGISTRATION AFFIDAVIT

Re: _____
Student's Name

I _____, have been informed by the Mount Holly Township School District Central Registration Office that I can only register students in this district if I am the parent and/or legal guardian of the above student.

Signing this form implies that I have stated to Registration Officials that I am the current parent and/or legal guardian of _____ and that I am aware that I am being allowed to register under that assumption, and that this registration can and will be terminated if this fact is found to be untrue at any time, and that if there is a change of guardianship, I must report it to this office immediately.

I am aware that any person who makes a false statement or permits false statements to be made concerning residence for the purpose of allowing non-resident students to attend Mount Holly Township Schools, commits a disorderly persons offense pursuant to N.J. 18A:38-1.

I hereby authorize the Mount Holly Township School District to investigate and confirm any and all statements by me in this affidavit.

_____ _____
Signature of Adult Registering Student) *Date*

Sworn to and subscribed Before me this _____ day of _____, 20__,

_____
(Signature of Notary)

Medicaid Annual Notification
Regarding Parental Consent

Background: The State of New Jersey has participated in a Federal program, Special Education Medicaid Initiative (SEMI), since 1994. The program assists school districts by providing partial reimbursement for medically-related services listed on a student's Individualized Educational Program (IEP).

The SEMI program is under the auspices of the New Jersey Department of the Treasury through its collaboration with the New Jersey Department of Education and New Jersey Division of Medicaid Assistance and Health Services.

In 2013, the regulations regarding Medicaid parental consent for school-based services changed. Now the regulations require that, prior to accessing a child's public benefits or insurance for the first time, and annually thereafter, school districts must provide parents/guardians written notification and obtain a one-time parental consent.

Is there a cost to you?
No. IEP services are provided to students while at school at no cost to the parent/guardian.

Will SEMI claiming impact your family's Medicaid benefits?
The SEMI program **does not** impact a family's Medicaid services, funds, or coverage limits. New Jersey operates the school-based services program differently than the family's Medicaid program. The SEMI program **does not** affect your family's Medicaid benefits in any way.

What type of services does the School-Based Services program cover?
- Evaluations
- Speech Therapy
- Occupational Therapy
- Physical Therapy
- Psychological Counseling
- Audiology
- Nursing
- Specialized Transportation

What type of information about your child will be shared?
In order to submit claims for SEMI reimbursement, the following types of records may be required: first name, last name, middle name, address, date of birth, student ID, Medicaid ID, disability, service dates and the type of services delivered.

Who will see this information?
Information about your child's special education program may be shared with the New Jersey Division of Medicaid Assistance and Health Services and its affiliates, including the Department of the Treasury and the Department of Education for the purpose of verifying Medicaid eligibility and submitting claims.

What if you change your mind?
You have the right to withdraw consent to allow for Medicaid billing at any time. If you would like to revoke consent, please contact the school in which your child is enrolled in writing.

Will your consent or refusal to consent affect your child's services?
No. Your school district is still required to provide services to your child pursuant to his or her IEP, regardless of your Medicaid eligibility status or your willingness to consent for SEMI billing.

What if you have questions?
Please call your school district's Special Education department with questions or concerns, or to obtain a copy of the parental consent form.

MOUNT HOLLY TOWNSHIP PUBLIC SCHOOLS

Special Services Office
331 Levis Drive, Mount Holly, NJ 08060

Tel: (609) 267-7108
ext. 7105, 7115
Fax: (609) 267-6480

Special Education Medicaid Initiative (SEMI) Parental Consent Form

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation,) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or public insurance to pay for special education or related services under Part 300 (services under the IDEA).

I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing.

I understand that billing for these services by the district **does not** impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name: _____

Child's Date of Birth: ____/____/____

Parent/Guardian: _____

Date: ____/____/____

I give consent to bill for SEMI: Yes ☐ No ☐

This consent can be revoked at any time by contacting your child's Case Manager, or the administrator at your child's school, in writing.

Mount Holly Township Schools

Home Language Survey*
Parent/Guardian Language Questionnaire

Name Of Student:_____ Age:_____
[first] [middle] [last]

Date of School Entrance_____

Person completing the survey: [ ] Mother [ ] Father [ ] Grandparent
[ ] Guardian [ ] Other _____

Directions: Check or write in the correct response for each of the following questions about your child.

1. What language did the child learn when he/she first began to talk?

   English_____ Other [specify]_____

2. What language does the family speak at home most of the time?

   English_____ Other [specify]_____

3. What language does the parent [guardian] speak to the child most of the time?

   English_____ Other [specify]_____

4. What language does the child speak to his/her parent [guardian] most of the time?

   English_____ Other [specify]_____

5. What language does the child speak to her/her brothers and sisters most of the time?

   English_____ Other [specify]_____

6. What language does the child speak to his/her friends most of the time?

   English_____ Other [specify]_____

7. In which language do you wish to receive school communication?

   English_____ Other [specify]_____

Signature:_____ Date:_____
[person completing the survey]

MOUNT HOLLY TOWNSHIP PUBLIC SCHOOLS-MOUNT HOLLY, NJ
HEALTH OFFICE INFORMATION FORM

Student's Name _____ DOB: _____ Grade: ____

Home Address: _____

Parent/Guardian's Name: _____

Student's Dentist: _____ Dentist's Phone: _____

Date of last Dental Exam: _____ Date of last Vision Exam: _____

Student's Physician: _____ Physician's Phone: _____

Date of last physical: _____ Purpose: ☐ Routine ☐ Illness

If illness, please explain: _____

Is student currently under a physician's care? Yes ☐ No ☐

In the past, has your child had any health problems in the following areas?

Asthma: _____

Allergies (Specify): _____ Epi-Pen: ☐ YES ☐ NO

Hives/Bee sting reactions: _____ Epi-Pen: ☐ YES ☐ NO

___Arthritis	___Headaches, frequent	___Skin Problems
___Asthma	___Hearing Aid/other device	___Sleep Problems
___Cancer	___Hearing Problem	___Sore Throat Frequent
___Concussion/Head Injury	___Heart Disease	___Speech Issues
___Constipation/Diarrhea	___Hemophilia	___Stomachaches, Frequent
___Cystic Fibrosis	___Hepatitis	___Surgery/Hospitalization
___Diabetes	___Kidney Disorders	___Tonsillectomy
___Ear Tubes Inserted	___Meningitis	___Vision Problem
___Eczema/Dermatitis	___Mononucleosis	___Glasses Contacts
___Epilepsy/Seizures	___Neurological Disorders	___Color Blindness
___Fainting	___Orthopedic Problems	
___Fractures	___Sickle Cell	

Please list details as needed if checking any of the above: _____

_____

Please list any illnesses within the last 12 months: _____

SIGNATURE OF PARENT/GUARDIAN: _____ Date: _____

Written consent required pursuant to 20 U.S.C. § 1232 g(b)(1) and 34 C.F.R. 99.30(b).

MOUNT HOLLY TOWNSHIP PUBLIC SCHOOLS
MEDICAL PERMISSION FOR HEALTH SERVICES

HEALTH OFFICE INFORMATION FORM (Page 2)

Student's Last Name _____ First Name _____

Does this child have any health insurance including NJ Family Care/Medicaid, Medicare, private or other?

☐ **No:** My child does not have health insurance. You may release my name and address to the NJ Family Care Program to contact me about health insurance. NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit WWW.njfamilycare.org to apply online.

☐ **Yes:** My child has health insurance (Please indicate insurance company below)

Name of child's health insurance company: _____

I understand that relevant information regarding my child's health may be shared with appropriate school personnel and other health care providers necessary.

In case of emergency, illness or accident the school is authorized to proceed as indicated on the District's Enrollment/Emergency Procedure Form

I hereby give permission for my child to receive the following medical attention as part of the school health program:

1. Height, weight, and blood pressure screening annually.
2. Vision/hearing screening every other year.
3. I understand that each student must have a physical examination upon entry into the Mount Holly Township School District. This examination must be done no more than 365 days prior to entry and must state what, if any, modifications are required for full participation in the school program. If a physical has not been done 365 days prior to entry to school, one must be done within 90 days of registration.
4. I understand the importance of obtaining subsequent examinations at least once during each of the student's development stages through my home physician:
   - Early childhood (pre-school through grade 3)
   - Pre-adolescence (grades 4 through 6)
   - Adolescence (grades 7 through 12)
5. I understand that scoliosis screening will be done by the school nurse on all students ages 10 to 18 bi-annually. Scoliosis is a lateral curve of the spine, most commonly found during the adolescent-growth period.
6. I have received information regarding the NJ Family Care Program for students who are knowingly without medical coverage.

If your child will need to take medication in school (i.e. Tylenol, Adderall, inhalers, etc.) please contact the nurse's office for the medication permission form. Students are not permitted to carry medication with them.

In most cases of extreme emergency the student will be taken to Virtua Hospital/Mount Holly via the emergency squad.

I understand that the relevant information regarding my child's health may be shared with appropriate school personnel and other health care providers as necessary.

SIGNATURE OF PARENT/GUARDIAN: _____ Date: _____

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student-Athlete Cardiac Assessment Professional Development module hosted by the New Jersey Department of Education.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)		Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?			
10. Have you ever had a seizure?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Unsure**	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? Unsure		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student - Athlete Cardiac Assessment Professional Development module Hosted by the New Jersey Department of Education.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)
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, e-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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N		
Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) _____		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

Preparticipation Physical Evaluation Medical Eligibility Form

The Medical Eligibility Form is the only form that should be submitted to school. It should be kept on file with the student's school health record.

Student Athlete's Name _____ Date of Birth _____

Date of Exam _____

- o Medically eligible for all sports without restriction
- o Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of
- o Medically eligible for certain sports
- o Not medically eligible pending further evaluation
- o Not medically eligible for any sports

Recommendations: _____

I have reviewed the history form and examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings- are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Signature of physician, APN, PA _____ Office stamp (optional)

Address: _____

Name of healthcare professional (print) _____

I certify I have completed the Cardiac Assessment Professional Development Module developed by the New Jersey Department of Education.

Signature of healthcare provider _____

Shared Health Information

Allergies _____

Medications:

Other information: _____

Emergency Contacts: _____

**This form has been modified to meet the statutes set forth by New Jersey.*