LAWTON C. JOHNSON SUMMIT MIDDLE SCHOOL

In order to begin the registration process you need:

_____1. Documentation of a physical less than 365 days old completed by a New Jersey doctor (submitted on the forms provided in this packet).

2. A complete immunization record including:

_____A. 3 doses of DPT (Diphtheria, Pertussia and Tetnus) or Td (Tetnus and Diphtheria).

If 5 years have elapsed since the last Tetnus/Tetnus Diphtheria booster, Tdap (Tetnus, Diphtheria and Pertussia) is required.

_____B. 3 doses of (OPV or IPV) Polio Vaccine.

_____C. 2 doses of (MMR) Measles, Mumps and Rubella Vaccine.

_____D. 3 doses of Hepatitis B Vaccine.

_____E. 1 does of Meningitis Vaccine.

Mantoux Testing (TB testing) is country specific. Any student transferring in from any country listed on the back of this page **Does Not** have to be TB tested. The Tuberculosis Program of the New Jersey Department of Health provides the list of countries annually.

THE FOLLOWING COUNTRIES HAVE A LOW INCIDENCE OF TB AND REQUIRE NO TB TESTING

Albania
America Samoa
Andorra
Antigua and Barbuda
Australia
Austria
Barbados
Belgium
Bermuda
British Virgin Islands
Canada
Cayman Islands
Chile
Cook Islands
Costa Rica
Cuba
Cyprus
Czech Republic
Denmark
Dominica
Finland
France
Germany
Greece
Greenland
Grenada
Iceland
Ireland
Israel
Italy
Hungary
Jamaica
Jordan
Lebanon
Luxembourg
Malta
Monaco
Montserrat
Netherlands
Netherlands Antilles
New Zealand
North Ireland
Norway
Oman
Puerto Rico
Saint Kitts and Nevis
St. Lucia
Samoa
San Marino
Slovakia
Slovenia
Sweden
Switzerland
Trinidad and Tobago
Turks and Caicos Islands
United Arab Emirates
United Kingdom of Great Britain and Northern Ireland
United States of America
United States Virgin Islands

Students entering a U.S. school for the first time in New Jersey or transferring into a New Jersey school from ANY country NOT listed above must receive an IGRA or Mantoux tuberculin skin test unless they meet an exemption criterion.

FROM THE HEALTH OFFICE

The State of New Jersey immunization requirements for entering sixth, seventh, and eighth grade students mandate three doses of Hepatitis B vaccine. In addition sixth graders are required to have meningitis and Tdap immunizations. New students may be provisionally admitted with documentation of the initial Hepatitis B vaccine and evidence of an appointment for the next. The series must be completed at the specified intervals. A separate letter has notified incoming sixth grade students who attended elementary school in Summit if these records are missing.

Students new to the district must also submit evidence of a physical completed within the past year by a New Jersey practitioner. Required forms are available in the guidance office or online at *www.summit.k12.nj.us* under *Athletics.*

The Middle School Cross Country and Field Hockey teams plan to start practice the first week of school. Required forms were distributed at the coaches meetings in June. These forms may be obtained at the Summit High School Athletic Office, the Main Office at the Middle School or from above website. Our school doctor must review forms before students are cleared to participate. Please mail the completed forms to the school nurse by the first week of August.

A note about serious nut and other allergies:

We have highly allergic children in each grade. Please read labels carefully when selecting snack foods for advisory programs and other occasions. Children who do eat foods containing peanut and other nut products are urged to wash their hands thoroughly after touching these foods to avoid serious ills for an allergic classmate. Thank you for reinforcing this information at home.

Scoliosis screening is required every two years unless parents decline in writing. This screening is done, individually and privately, at the same time as other routine screenings of height, weight, vision, hearing, and blood pressure.

Ms. Mary Ellen McDonald
LCJSMS School Nurse

SUMMIT PUBLIC SCHOOLS

Lawton C. Johnson Summit Middle School • 272 Morris Avenue • Summit, New Jersey 07901
Telephone (908) 273-1190 • Fax: (908) 273-8320 • Website: www.summit.k12.nj.us

Mr. Damen G. Cooper, Principal
Mr. Nicholas A. Grimshaw, Assistant Principal
Mrs. Carly S. Johnson, Assistant Principal

Dear Parent/Guardian,

In order to insure:

A. that the learning potential of each student is not diminished by a remedial physical disability,
B. that the student is able to participate in the school program
C. and that the school community is protected from the spread of communicable disease

Each student **must be examined upon entry into the school district.** The Annual Athletic Pre-participation Physical Examination Form (attached) is the only set of forms that will be accepted to fulfill this requirement. The 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. Each student medical examination must be conducted by a physician licensed to practice medicine and surgery within the State of New Jersey or by a nurse practitioner/clinical nurse specialist certified by the New Jersey Board of Nursing working in collaboration with a physician licensed to practice medicine and surgery within the State of New Jersey at the provider's facility and a full report of the examination documented on the attached form must be presented to the school.

Continuity of care by your pediatrician/primary health care provider during the development of a child is an ideal medical practice. It is during your child's regularly scheduled health examination that his/her needs for intervention, immunization and Tuberculin testing may be addressed. The Summit Board of Education and the State of New Jersey strongly support the importance of obtaining physical exams on the child at least once during each of the student's developmental stages:

* early childhood (preschool through grade 3)
* preadolescence (grades 4 through 6)
* adolescence (grades 7 through 12)

Immunization information:
Documentation of required immunizations is mandated in regulations issued by the New Jersey State Department of Health. A summary of the immunization information required to enable your child to register for school follows:

Diphtheria, Pertussis and Tetanus Vaccine (DPT and/or Tdap/Td/TT) - The student must have a minimum of 3 doses. One dose of Tdap is required if no boosters for Tdap are noted and five years have elapsed from the last TD dose.

Polio Vaccine (OPV and/or IPV) -The student must have received at least 3 doses.

Measles Vaccine - The student must receive two doses of measles vaccine. The first administered on or after the first birthday. If the student had the disease, **documented laboratory evidence** of measles immunity is required.

Rubella Vaccine - The student must receive one dose of rubella vaccine administered on or after the first birthday. If the student had the disease, **documented laboratory evidence** of rubella immunity is required.

Mumps Vaccine - The student must receive one dose of the mumps vaccine administers on or after the first birthday. If the student had the disease, **documented laboratory evidence** of mumps immunity is required.

Hepatitis B Vaccine - The student must have received three doses.

Meningcoccal Vaccine - The student must have received one dose.

Mantoux (tuberculin) Testing - Is required as per the specifications established by the Department of Health and Senior Services. The Mantoux test must be accomplished less than 6 months prior to registration for school.

Sport information:

Each candidate for a school athletic squad or team is to be examined within 365 days prior to the first practice session. The Annual Athletic Pre-participation Physical Examination Form is the only set for forms that will be accepted to fulfill this requirement. The physical exam must be accomplished by a physician licensed to practice medicine and surgery within the State of New Jersey or by a nurse practitioner/clinical nurse specialist certified by the New Jersey Board of Nursing working in collaboration with a physician licensed to practice in the State of New Jersey. A health history questionnaire will be required for each additional sport. If the athlete has been injured documented evidence of his/ her ability to return to the sport by his/her doctor, advanced practice nurse or clinical nurse specialist is necessary.

*A **medical home** as defined by the N.J. Department of Education is a health care provider (physician or advanced practice nurse) and that provider's practice site chosen by the student's parent/guardian for the provision of health care.

Parents of student's who do not have a medical home can utilize the services of:

1. Private Practitioner
2. Overlook Hospital Family Practice (908-522-5700)
3. EMO-Berkeley Heights (908-464-6700)
4. The Care Station-Springfield (973-464-2273)

Immunizations may be obtained from:

1. Private Practitioner
2. Overlook Hospital Family Practice
3. EMO
4. The Care Station
5. Summit Board of Health (908-277-6464)
6. Union County Immunization Center-Elizabeth (908-965-2734 or 908-965-3868)

*Any parent child who chooses to utilize the Union County Immunization Center must present with:

1. School referral Form,
2. Proof of the child's birth, such as a birth certificate and/or passport,
3. Proof of parental/ guardian identification,
4. Proof of residency in Union County.

SUMMIT PUBLIC SCHOOLS
MEDICAL EVALUATION FORM

PAGE 1/2 #7

NAME:_____ DOB:_____

PAST MEDICAL HISTORY: _____

PAST SURGICAL HISTORY:_____

HOSPITALIZATION OR INJURIES:_____

MEDICATIONS: _____

ALLERGIES:_____

To be completed by the health care practitioner

Please complete both pages

Date of Physical:_____

Height:	
Weight:	
Blood Pressure:	
Pulse:	
Vision:	
With Glasses:	
Without Glasses:	
Hearing Right:	
Hearing Left:	

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Doses Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination *(If Td or DT, indicate in upper corner)					
Tdap					
POLIO - INACTIVATED POLIO VACCINE (IPV) If oral vaccine, indicate (OPV) in upper corner					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE					
MENIGOCOCCAL					
HEPATITIS A					
HPV (HUMAN PAPILLOMAVIRUS)					
INFLUENZA					
OTHER					

LEAD SCREENING	
Test Date	Result

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer
Mumps	Date:	Titer:
Rubella	Date:	Titer:

HISTORY	YEAR
Allergies	
Asthma	
Congenital Disorder	
Convulsive Disorder	
Diabetes	
Neuromuscular Disorder	
Chronic Otitis Media	
Auto Immune Disorders	
Strep Infections	
Juvenile Rheumatoid Arthritis	
Autism Spectrum Disorders	
Drug Allergies	
Heart Disease	
Hepatitis	
Lyme Disease	
Mononucleosis	
Hematological Disorders	
Operations and Injuries	

	TB Screening (Mantoux Test) Date	Date	Date
Tested			
Read			
Result			

Chest X-Ray Date	Chest X-Ray Date	Result Normal

Medication

Reactor No RX ☐

Date Started_____

Date Completed_____

Provisional admission attached:

Date Granted_____

___Medical Exemption

___Religious Exemption

SUMMIT PUBLIC SCHOOLS

Lawton C. Johnson Summit Middle School • 272 Morris Avenue • Summit New Jersey 07901
Telephone: (908) 273-1190 • FAX: (908) 273-8320 • Website: www.summit.k12.nj.us

ATHLETIC ELIGIBILTY REQUIRMENTS

Congratulations on making the decision to participate in athletics! To be eligible to play, you must complete the following requirements:

1. You must have a current physical dated within 365 days of the first official practice session. Part A of the forms must be filled out by a parent or guardian and taken to the physician to be reviewed at the time of the physical. The physician will then complete Part B. These are NJ State required forms and will be the only forms accepted.
2. The Permission to Participate in Athletics/Insurance Information sheet must be completed.
3. The athlete and the parent/guardian must sign the Consent Form, stating that you have read the provided information about steroid testing, concussions, and sudden cardiac death.
4. Finally, a completed and signed Emergency Form must be turned in, as well.
5. Return all completed forms to the LCJSMS main or nurse's office or mail them to:

Mary Ellen McDonald
Lawton C. Johnson Summit Middle School
272 Morris Avenue
Summit, NJ 07901

* **If your physical cannot be scheduled until after the return date, please return all other forms, with the exception of Parts A and B, ahead of time.**

DO NOT DELAY RETURNING THESE FORMS. THE SCHOOL PHYSICIAN MUST REVIEW THEM BEFORE YOU WILL BE CLEARED TO PARTICIPATE!

* **We understand that insurance companies will only allow one physical within 365 days. Some companies will waive that policy if you contact them and explain the time constraints. Please make every effort to return your paperwork as soon as possible.**

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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 _____

HE0803 9-2681/0410

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

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

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).

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		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]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 _____

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

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 _____

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

SUMMIT MIDDLE SCHOOL

CONSENT FORM

This form MUST be returned with either Part A and B of the Annual Athletic Pre-Participation Physical Examination Form or the Health History Update form and the Permission To Participate/Insurance form.

I have read the information provided to me regarding:

_____NJSIAA concussion policy

_____NJSIAA Sudden Cardiac Death in Athletes

Date:____/_____/____Grade:_____Sport:_____

_____ _____

PRINT STUDENT NAME SIGNATURE OF STUDENT

_____ _____

PRINT PARENT/GUARDIAN SIGNATURE OF PARENT/GUARDIAN

SUMMIT PUBLIC SCHOOLS
PERMISSION TO PARTICIPATE IN ATHLETICS
INSURANCE INFORMATION
(TO BE FILLED OUT *EACH SEASON* BY PARENT OR GUARDIAN)

STUDENT NAME: _____
(PLEASE PRINT)

SPORT: _____ GRADE: _____

DATE OF BIRTH____/_____/_____PLACE OF BIRTH: _____
(city/state/country)

DATE FIRST ENTERED LCJSMS: _____ (month/year)

INSURANCE INFORMATION

The Summit Board of Education provides insurance coverage for all participants in the interscholastic athletic program while engaging in practice sessions, games, and travel to and from events on school provided transportation. The type of coverage is a *full excess* plan covering any medical expenses incurred by the athlete within the limits of the policy. *Full excess* provides that all claims must be submitted first to the family policy carrier, including a major medical plan. The school policy will cover the balance of the costs within the limits of coverage. If an athlete has no other medical insurance in effect, the school policy becomes the *primary* coverage and will pay all medical cost within the limits of the policy. The school policy payment of the difference is the responsibility of the athlete's parents. The form can be obtained through the athletic training office as long as the injury has been reported within 90 days of the date of the accident.

INFORMED CONSENT

I/We realize that participation in the _____program involves the potential for injury, which is inherent in all sports. On rare occasions these injuries can be so severe as to result in total disability, paralysis or even death. I hereby authorize the school athletic trainer and/or school approved physician to evaluate and treat any injury accordingly.

DECLARATION

I/We have read all the information herein and grant permission for my/our son/daughter to participate.

_____ _____
PARENT /GUARDIAN SIGNATURE DATE

_____
PARENT/GUARDIAN ***PRINTED*** NAME

5/2004

ATHLETIC EMERGENCY FORM

Grade:_____School Year:_____Sport: _____

Name:_____Birth Date:_____
Last *First*

Address:_____
Street *Town* *Zip*

Home Phone_____

Mother's Phone:_____Cell:_____

Father's Phone:_____Cell:_____

In case of Emergency and a parent cannot be located please notify:

_____
Name/Relationship *Phone Number*

Insurance Company:_____ HMO? Yes:_____ No:_____

Need Referral? Yes:_____ No:_____

Primary Care Physician:_____Phone:_____

Orthopedic Group/Physician:_____Phone:_____

Athlete Has/Needs

Allergies:_____Uses Epipen:_____

Glasses/Contacts:_____ Orthodontic Braces:_____Supportive Braces_____

Uses Inhaler? Yes:_____ No:_____

Other conditions:_____

In case of injury, I request that I be notified as soon as possible:

Parent/Guardian:_____Date:_____

NJSIAA PARENT/GUARDIAN CONCUSSION POLICY ACKNOWLEDGMENT FORM

In order to help protect the student athletes of New Jersey, the NJSIAA has mandated that all athletes, parents/guardians and coaches follow the NJSIAA Concussion Policy. A concussion is a brain injury and all brain injuries are serious. They may be caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious.

You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child/player reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

1. Headache.
2. Nausea/vomiting.
3. Balance problems or dizziness.
4. Double vision or changes in vision.
5. Sensitivity to light or sound/noise.
6. Feeling of sluggishness or fogginess.
7. Difficulty with concentration, short-term memory, and/or confusion.
8. Irritability or agitation.
9. Depression or anxiety.
10. Sleep disturbance.

Signs observed by teammates, parents and coaches include:

1. Appears dazed, stunned, or disoriented.
2. Forgets plays or demonstrates short-term memory difficulties (e.g. is unsure of the game, score, or opponent)
3. Exhibits difficulties with balance or coordination.
4. Answers questions slowly or inaccurately.
5. Loses consciousness.
6. Demonstrates behavior or personality changes.
7. Is unable to recall events prior to or after the hit.

What can happen if my child/player keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from

play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete's safety.

If you think your child/player has suffered a concussion:
Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear. Close observation of the athlete should continue for several hours. An athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time and may not return to play until the athlete is evaluated by a medical doctor or doctor of Osteopathy, trained in the evaluation and management of concussion and received written clearance to return to play from that health care provider. You should also inform you child's Coach, Athletic Trainer (ATC), and/or Athletic Director, if you think that your child/player may have a concussion. And when it doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:
http://www.cdc.gov/ConcussionInYouthSports/
www.nfhslearn.com