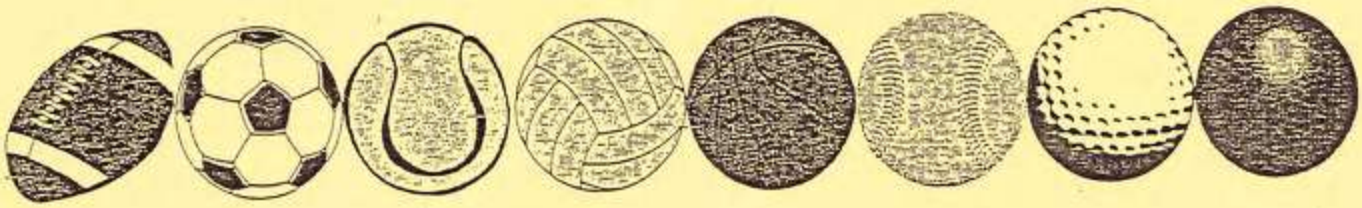

NPS SPORTS PHYSICAL DOCUMENTS

*These documents must be filled out completely prior to the examination.

Newark Public Schools
Office of Health Services

Request/Consent for Medical Examination
By the School Physician

Name_____Birth date _____Grade/Room_____

Parent/Guardian_____Phone (work)_____

(home)_____

I understand that the laws of the New Jersey Departments of Education and Health require that each student must be examined upon entry into the school district.

_____ I am requesting that my child be examined by the School Physician.

Therefore, I give my consent to the Newark Public Schools' School Physician to provide a physical examination for my child. I will be notified of any abnormal findings, and will be responsible to seek further medical care.

Family Physician/Primary Health Care Provider Medical Examination

_____ My child has a medical care provider, who shall provide the physical examination for my child. I am responsible for submitting the completed physical examination form to the school nurse within 30 days.

I understand that it is highly recommended that all students have a medical examination at least once up to 3rd grade, once between 4th and 8th grades, and once between 7th and 12th grades.

Parent/Guardian
Signature_____Date_____

NEWARK PUBLIC SCHOOLS

PERMISSION FORM FOR ATHLETIC COMPETITION

Last Name First MI DOB Age Sex

Grade Homeroom Institute/Academy

Home Address

Father or Guardian's Full Name Home # Work #

Mother or Guardian's Full Name Home # Work #

Family Physician Address Phone #

In case of an emergency, contact: (other than parent or guardian)

Name Address Phone #

School Attended Last Year Previously Played Sport

Nurse's Signature Date

___ Boys

_____ Baseball
_____ Cheerleading
_____ Basketball
_____ Golf
_____ Bowling

___ Girls

_____ Cross Country
_____ Football
_____ Soccer
_____ Volleyball
_____ Softball
_____ Track
_____ Ice Hockey
_____ Tennis
_____ Winterguard
_____ Swimming
_____ Wrestling

NOTE: PLEASE RETURN TO THE ATHLETICS DIRECTOR OR COACH WHEN COMPLETED.

NEWARK PUBLIC SCHOOLS
PERMISSION FORM FOR ATHLETIC COMPETITION

Please complete this form in ink.

I/we request that my/our child _____ be permitted to participate in _____ as carried out in the school including practice sessions and contests with other schools. In consideration of such permission, it is represented and agreed as follows:

1. That said child is physically able to compete in said sport.

2. I/we realizing that such activity involves the potential for injury which is inherent in all sports, I/we acknowledge that even with the best coaching, use of the most protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions, these injuries can be so severe as to result in total disability, paralysis or even death. I/we acknowledge that I/we have read and understand this warning.

3. That said child issued equipment and supplies, which must be returned on demand or replaced if lost or stolen. It is understood that I am not to be charged for any damage due to wear and tear through legitimate use. The student may use school facilities to store equipment, but is responsible for equipment once it has been issued. It may be taken home for cleaning and storage.

4. That I/we authorize the school physician to provide necessary medication or treatment to child if injured or ill, and if it is deemed necessary, to have child admitted and treated (including medication) in the hospital until the arrival of a family physician.

5. That neither the Newark Public Schools nor any of its employees shall be liable to the undersigned or to the pupil for any claims arising out of or during such participation, said claims be hereby waived, and the undersigned releases the said Newark Public Schools, its employees, teachers, and principal from any and all liability and claims for personal injury to said pupil, expenses or property damage.

6. That said child has hospital and medical surgical insurance coverage and/or is insured through the school. I/we acknowledge receipt of the Certificate of Insurance that describes the benefits and conclusion of the insurance program in force for the athletes and other participants in the Athletics Office.

7. FOOTBALL PLAYERS ONLY: That I/we acknowledge and understand the following warning: no helmet can prevent all head and neck injuries that a player might receive while participating in football. A helmet must not be used to butt, ram, or spear an opposing player. This is a violation of the football rules and such use can result in severe head or neck injuries, paralysis or death and possible injury to the opponent as well.

DECLARATION OF AGREEMENT

I/we certify that the undersigned student is an amateur and is eligible to compete under the rules of the New Jersey State Interscholastic Athletic Association. He/she requests to be enrolled as a candidate for a place on the school team in the above-specified sport. He/she acknowledges the fact that physical hazards may be encountered and waives all claims against the Newark Public Schools and its employees for damages to themselves or other persons in their behalf for personal injuries that occur during participation in the sport.

_____ _____ _____ _____

Parent or Guardian's Signature Date Pupil's Signature Date

XXX

New Jersey Department of Education
ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the parent and student and reviewed by examining provider
Part B: PHYSICAL EVALUATION FORM-Completed by examining licensed provider with MD, DO, APN or PA

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date:_____ Date of Last Sports Physical: _____

Student's Name: _____ Sex: M F (circle one) Age: ____ Grade: _____

Date of Birth: ____/____/_____ School: _____ District: _____

Sport(s): _____ Home Phone: (____) _____

Provider Name (Medical Home): _____ Phone: _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name of parent/guardian: _____ Relationship to student: _____

Phone (work): _____ Phone (home): _____ Phone (cell): _____

Additional emergency contact: _____ Relationship to student: _____

Phone (work): _____ Phone (home): _____ Phone (cell): _____

Directions: Please answer the following questions about the student's medical history by CIRCLING the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. **Have you ever had, or do you currently have:**
   a. Restriction from sports for a health related problem? Y / N / Don't Know
   b. An injury or illness since your last exam? Y / N / Don't Know
   c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know
      (1.) An inhaler or other prescription medicine to control asthma? Y / N / Don't Know
   d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know
   e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
   f. Any **allergies** to medications? **Y / N / Don't Know**
   g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't Know
      (1.) If yes, check type of reaction:

      ☐ Rash ☐ Hives ☐ Breathing or other anaphylactic reaction

      (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) Y / N / Don't Know
   h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know
   i. A blood relative who died before age 50? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____

_____

_____

_____

_____

List all medications here:

Medication Name	Dosage	Frequency

2. **Have you ever had, or do you currently have, any of the following *head-related* conditions:**

a. Concussion or head injury (including "bell rung" or a "ding")?	Y / N / Don't Know
b. Memory loss?	Y / N / Don't Know
c. Knocked out?	Y / N / Don't Know
c. A seizure?	Y / N / Don't Know
d. Frequent or severe headaches (With or without exercise)?	Y / N / Don't Know
e. Fuzzy or blurry vision	Y / N / Don't Know
f. Sensitivity to light/noise	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

3. **Have you ever had, or do you currently have, any of the following *heart-related* conditions:**

a. Restriction from sports for heart problems?	Y / N / Don't Know
b. Chest pain or discomfort?	Y / N / Don't Know
c. Heart murmur?	Y / N / Don't Know
d. High blood pressure?	Y / N / Don't Know
e. Elevated cholesterol level?	Y / N / Don't Know
f. Heart infection?	Y / N / Don't Know
g. Dizziness or passing out during or after exercise without known cause?	Y / N / Don't Know
h. Has a provider ever ordered a heart test (EKG, echocardiogram, stress test, Holter monitor)?	Y / N / Don't Know
i. Racing or skipped heartbeats?	Y / N / Don't Know
j. Unexplained difficulty breathing or fatigue during exercise?	Y / N / Don't Know
k. Any family member (blood relative):	
(1.) Under age 50 with a heart condition?	Y / N / Don't Know
(2.) With Marfan Syndrome?	Y / N / Don't Know
(3.) Died of a heart problem before age 50? If yes, at what age? _____	Y / N / Don't Know
(4.) Died with no known reason?	Y / N / Don't Know
(5.) Died while exercising? If yes, was it during or after? (Circle one.)	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

4. **Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat conditions:***

a. Vision problems?	Y / N / Don't Know
(1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.)	Y / N / Don't Know
b. Hearing loss or problems?	Y / N / Don't Know
(1.) Wear hearing aides or implants?	Y / N / Don't Know
c. Nasal fractures or frequent nose bleeds?	Y / N / Don't Know
d. Wear braces, retainer or protective mouth gear?	Y / N / Don't Know
e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)?	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

5. **Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic conditions:***

a. Numbness, a "burner", "stinger" or pinched nerve?	Y / N / Don't Know
b. A sprain?	Y / N / Don't Know
c. A strain?	Y / N / Don't Know
d. Swelling or pain in muscles, tendons, bones or joints?	Y / N / Don't Know
e. Dislocated joint(s)?	Y / N / Don't Know
f. Upper or lower back pain?	Y / N / Don't Know
g. Fracture(s), stress fracture(s), or broken bone(s)?	Y / N / Don't Know
h. Do you wear any protective braces or equipment?	Y / N / Don't Know

Explain all (yes) answers here (include relevant dates):

6. Have you ever had or do you currently have any of the following *general or exercise related conditions*:

a. Difficulty breathing?	Y / N / Don't Know
(1.) During exercise?	Y / N / Don't Know
(2.) After running one mile?	Y / N / Don't Know
(3.) Coughing, wheezing or shortness of breath in weather changes?	Y / N / Don't Know
(4.) Exercise-induced asthma?	Y / N / Don't Know
i. Controlled with medication? (specify _____)	Y / N / Don't Know
ii. Experience dizziness, passing out or fainting?	Y / N / Don't Know
b. Viral infections (e.g. mono, hepatitis, coxsackie virus)?	Y / N / Don't Know
c. Become tired more quickly than others?	Y / N / Don't Know
d. Any of the following skin conditions:	
(1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts?	Y / N / Don't Know
(2.) Sun sensitivity?	Y / N / Don't Know
e. Weight gain/loss (of 10 pounds or more)?	Y / N / Don't Know
(1.) Do you want to weigh more or less than you do now?	Y / N / Don't Know
f. Ever had feelings of depression?	Y / N / Don't Know
g. Heat-related problems (dehydration, dizziness, fatigue, headache)?	Y / N / Don't Know
(1.) Heat exhaustion (cool, clammy, damp skin)?	Y / N / Don't Know
(2.) Heat stroke (hot, red, dry skin)?	Y / N / Don't Know
(3.) Muscle cramps?	Y / N / Don't Know
h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)?	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____

_____

_____

7. **Females only:**
Age of onset of menstruation:_____ How many menstrual periods in the last twelve (12) months? _____

How many periods missed in the last twelve (12) months? _____

8. **Males only:**
Have you had any swelling or pain in your testicles or groin? Y / N / Don't Know

_____

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

_____ _____

Signature, Parent/Guardian or Student Age 18 Date of Signature:

THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.

ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

Part B: Physical Evaluation Form

(Completed by the examining licensed provider MD, DO, APN or PA)

-STUDENT INFORMATION-

Student's Name: _____ Sport(s): _____

Sex: M F (circle one) Age: _____ Grade: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____ Home Phone: _____

School: _____ District: _____

Parent/Guardian's Full Name: _____

- EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

If conducted by school physician check here ☐

Name: _____ Phone: _____ Fax: _____

Address: _____ City/State/Zip: _____

- FINDINGS OF PHYSICAL EVALUATION -

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____bpm.

Vision: R 20/____ L 20/____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it: Louder Softer No Change
		Squatting makes it: Louder Softer No Change
		Valsalva makes it: Louder Softer No Change
Femoral Pulses	YES	
Lungs: Auscultation/Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Assessment of physical maturation or Tanner Scale	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	
Hernia	ABSENT	
Evidence of Marfan Syndrome	ABSENT	

NJDOE/APPEF Revised 3/10

Use of this form is required by N.J.A.C. 6A:16-*Programs to Support Student Development*

Most recent immunizations and dates administered:

Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Additional observations:

General Diagnosis:

General Recommendations:

THE HISTORY PREPARED BY THE PARENT/STUDENT MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE PHYSICAL EXAMINATION.

CLEARANCES: This section is completed by the examining healthcare provider.

After examining the student and reviewing the medical history the student is:

☐ A. Cleared for participation in all sports without restrictions.

☐ B. Not cleared for participation in any sport until evaluation/treatment of:

_____

☐ C. Cleared for limited participation in the following types of sports only. Please see below for sport classifications. CHECK ALL THAT APPLY

___ CONTACT/COLLISION
___ LIMITED CONTACT
___ NON-CONTACT/STRENUOUS
___ NON-CONTACT/NON-STRENUOUS

Limitations due to: _____

_____

NOTES TO THE EXAMINING PROVIDER

Conditions requiring clearance before sports participation include, but are not limited to the following:

Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; Seizure Disorder; Marfan's Syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Basketball	Baseball	Discus	Bowling
Diving	Cheerleading	Javelin	Golf
Field Hockey	Fencing	Shot put	
Football	High Jump	Rowing	
Ice Hockey	Pole vault	Running/Cross Country	
Lacrosse	Gymnastics	Strength Training	
Soccer	Skiing	Swimming	
Wrestling	Softball	Tennis	
	Volleyball	Track	

Effects of physiologic maneuvers on heart sounds

Standing	Increases murmur of HCM Decreases murmur of AS, MR MVP click occurs earlier in systole
Squatting	Increases murmur of AS, MR, AI Decreases murmur of MCH MVP click delayed
Valsalva	Increases murmur of HCM Decreases murmur of AS, MR MVP click occurs earlier in systole

HCM: Hypertrophic Cardio Myopathy
AS: Aortic Stenosis
AI: Aortic Insufficiency
MR: Mitral Regugitation
MVP: Mitral Valve Prolapse

Physical Stigmata of Marfan's Syndrome

Kyphosis
High arched palate
Pectus excavatum
Arachnodactyly
Arm span > height 1.05:1 or greater
Mitral Valve Prolapse
Aortic Insufficiency
Myopia
Lenticular dislocation

HISTORY REVIEWED AND STUDENT EXAMINED BY: Physician's/Provider's Stamp:

☐ Primary Care Provider
☐ School Physician Provider
☐ License Type:
  ☐ MD/DO
  ☐ APN
  ☐ PA

PHYSICIAN'S/PROVIDER'S SIGNATURE: _____

Today's Date: _____ Date of Exam: _____

RESERVED FOR SCHOOL DISTRICT USE

NOTE: *N.J.A.C. 6A:16-2.2* requires the school physician to provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this physical evaluation. This evaluation and the notification letter become part of the student's school health record.

History and Physical Reviewed By: _____ Date: _____

Title of Reviewer (please check one): ☐ School Nurse ☐ School Physician

Medical Eligibility Notification Sent to Parent/Guardian by School Physician _____ Date

☐ Letter of notification is attached.

OR

Parent notification indicates that:

☐ Participation Approved without limitations.

☐ Participation Approved with limitations pending evaluation.

☐ Participation NOT Approved

Reason(s) for Disapproval: _____

_____

NJSIAA

1161 Route 130, P.O. Box 487, Robbinsville, NJ 08691 609-259-2776 609-259-3047-Fax

NJSIAA STEROID TESTING POLICY

CONSENT TO RANDOM TESTING

In Executive Order 72, issued December 20, 2005, Governor Richard Codey directed the New Jersey Department of Education to work in conjunction with the New Jersey State Interscholastic Athletic Association (NJSIAA) to develop and implement a program of random testing for steroids, of teams and individuals qualifying for championship games.

Beginning in the Fall, 2006 sports season, any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances on the attached page, without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition. The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing.

By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that, if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

_____

Signature of Student-Athlete Print Student-Athlete's Name Date

_____

Signature of Parent/Guardian Print Parent/Guardian's Name Date

May 1, 2009

CHANGING HEARTS AND MINDS TO VALUE EDUCATION

NPS ATHLETICS "GAME POINT" TASK FORCE
MEMORANDUM of UNDERSTANDING

We, the undersigned have read and reviewed Policy Code 6145. We understand its content and will adhere to the rules and regulations of the district in order for my child to participate in athletics or extracurricular activities.

It is our understanding that my child must maintain proper attendance and academic eligibility throughout their academic history for athletic or extracurricular participation.

I am aware that I can request a one-time probationary period for my child with a GPA between 1.5 to 1.9 and that supports will be in place to help raise my child's GPA.

I am also aware that while eligibility begins with a GPA of 2.0 and higher, my child will be required to attend mandatory tutorials if their GPA is between 2.0 to 2.5.

Student's Name (Print)	Sport(s)
Parent's/Guardian's Signature	Home Telephone Number
Student's Signature	School
Date	

The Newark Public Schools

2 Cedar Street, Newark, NJ 07102

State District Superintendent

Dr. Clifford B. Janey

PARENTAL CONSENT FORM

This form is for media interviews & video tapings of students for publications and programs. Parent's permission must be obtained prior to television, film, video or print publication interviews. This also applies to photographs of students taken for the various media.

I understand that this is designed to showcase my son/daughter's participation in an athletic setting and is not for a profit venture.

I, _____ the parent(s) of _____
(Parent's/guardian's name) (Student's name)

at _____ School, do grant my permission for my son/daughter
(Name of school)

to appear in an article/photograph/televised news program and events.

_____
(Date)

_____
(Parent's/guardian's signature)

_____
(Street address, city and state)

Please return to the Athletic Director.

CHANGING HEARTS AND MINDS TO VALUE EDUCATION