



NPS SPORTS PHYSICAL DOCUMENTS

BARRINGER HIGH SCHOOL

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

Hand in completed packets directly to;

**Head Coach,
Athletic Trainer or Head of Athletics.**

**Newark Public Schools
Office of Health Services**

**Request/Consent for Medical Examination
By the School Physician**

CHANGING HEARTS AND MINDS TO VALUE EDUCATION

■ 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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> 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 _____

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■ 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

- 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP	Pulse	Vision R 20/ <input type="checkbox"/> L 20/ <input type="checkbox"/> Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> Marian stigmata (scoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 		
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart* <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 		
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 		
Lungs		
Abdomen		
Genitourinary (males only)*		
Skin <ul style="list-style-type: none"> HSV lesions suggestive of MRSA, tinea corporis 		
Neurologic*		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional <ul style="list-style-type: none"> Duck-walk, single leg hop 		

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

*Consider GU exam if in private setting. Having third party present is recommended.

*Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- ☐ Not cleared
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

■ 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 STATE INTERSCHOLASTIC ATHLETIC ASSOCIATION

1161 Route 130 North, Robbinsville, NJ 08691-1104

COVID-19 Questionnaire

Name of Student: _____ Date: _____

Parent/Guardian Cell: _____ Sport: _____

COVID-19 Questions:

Please Circle One

Has your son/daughter been diagnosed with Coronavirus (COVID-19)? YES NO

• If diagnosed with Coronavirus (COVID-19), was your son/daughter symptomatic? YES NO

• If diagnosed with Coronavirus (COVID-19), was your son/daughter hospitalized? YES NO

Has any member of the student-athlete's household been diagnosed with Coronavirus (COVID-19)? YES NO

Signature of Parent/Guardian: _____

To participate in workouts during the summer recess period, the parent/guardian must complete this form. This form only needs to be completed one time. This is a recommended template for the COVID-19 Questionnaire. Districts can determine the best means (electronic or paper) and platform (Survey Monkey, Microsoft Teams, Google Docs etc.) to administer the questionnaire.

Newark Board of Education COVID 19 Testing Consent Form

Parent/Guardian Information

Parent/Guardian Name:

Address:

**Parent/Guardian
Tel./Mobile #:**

Parent/Guardian Email:

Student Information

Student Name:

Student School ID#:

**Date of Birth
(mm/dd/yyyy)**

Student School:

Consent

By signing below, I attest that:

- ☐ I have signed this form freely and voluntarily, and I am legally authorized to make decisions for the child named above.
- ☐ I consent for my child to be tested for COVID-19 infection.
- ☐ I consent for the results to be shared with the district's Office of Health Services and school's Health Office.
- ☐ I understand that my child may be tested at multiple times through June 30, 2021, and that testing may occur (1) in accordance with city mandates, such as weekly testing in schools, and for routine testing of student-athletes or participants in afterschool activities, or (2) if they are a close contact of a student, coach, teacher, or staff person with COVID-19 infection.
- ☐ I understand that this consent form will be valid through June 30, 2021, unless I notify the designated contact person from my child's school in writing that I revoke my consent.
- ☐ I understand that my child's test results and other information may be disclosed as permitted by law.
- ☐ I understand that if I am a student age 18 or older, or may otherwise legally consent for my own health care, references to "my child" refer to me and I may sign this form on my own behalf.

**Signature of Parent/ Guardian*
(if child is under age 18)**

Date:

**Signature of Student (if age 18 or
over or otherwise authorized to
consent)**

Date: