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?	
(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	

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: _____

_____