PARENTS:

Previous School: ____________________________

School Doctor will be here on: ________________

NOTICE REGARDING PHYSICALS

Due to change in the New Jersey Administrative Code (N.J.A.C. 6A:16-22) “each student medical examination shall be conducted at the medical home (student’s family physician or healthcare provider) of the student.” For example, the student’s physician or nurse practitioner/clinical nurse specialist may be acceptable.

If a student does not have a medical home (doctor), the school physician will perform the student medical examination in a district school health office, after the parent/guardian signs the form that they do not have a family physician or healthcare provider.

Student’s Name (Print Name) ____________________________ Grade/ID Number ____________________________

(check one)

____ we will provide a physical from our family physician or health care provider.

____ we do not have a medical home physician and will need a physical exam from the district.

(check one)

____ your child has health insurance.

____ if not, would you be interested in having the school nurse provide information regarding the New Jersey State insurance plan?

Parent/Guardian Signature ____________________________

Date ____________________________
**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 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**

1. Has a doctor ever denied or restricted your participation in sports for any reason? [ ] Yes [ ] No
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? [ ] Yes [ ] No
4. Have you ever had surgery? [ ] Yes [ ] No

**HEART HEALTH QUESTIONS ABOUT YOU**

5. Have you ever passed out or nearly passed out DURING or AFTER exercise? [ ] Yes [ ] No
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? [ ] Yes [ ] No
7. Does your heart ever race or skip beats (irregular beats) during exercise? [ ] Yes [ ] No
8. Has a doctor ever told you that you have 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) [ ] Yes [ ] No
10. Do you get lightheaded or feel more short of breath than expected during exercise? [ ] Yes [ ] No
11. Have you ever had an unexplained seizure? [ ] Yes [ ] No
12. Do you get more tired or short of breath more quickly than your friends during exercise? [ ] Yes [ ] No

**HEART HEALTH QUESTIONS ABOUT YOUR FAMILY**

13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50? [ ] Yes [ ] No
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, catecholaminergic polymorphic ventricular tachycardia? [ ] Yes [ ] No
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? [ ] Yes [ ] No
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? [ ] Yes [ ] No

**BONE AND JOINT QUESTIONS**

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? [ ] Yes [ ] No
18. Have you ever had any broken or fractured bones or dislocated joints? [ ] Yes [ ] No
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? [ ] Yes [ ] No
20. Have you ever had a stress fracture? [ ] Yes [ ] No
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) [ ] Yes [ ] No
22. Do you regularly use a brace, orthotics, or other assistive device? [ ] Yes [ ] No
23. Do you have a bone, muscle, or joint injury that bothers you? [ ] Yes [ ] No
24. Do any of your joints become painful, swollen, feel warm, or look red? [ ] Yes [ ] No
25. Do you have any history of juvenile arthritis or connective tissue disease? [ ] Yes [ ] No

---

**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 9-2901-0410
# Preparticipation Physical Evaluation

## The Athlete with Special Needs: Supplemental History Form

**Date of Exam** ________________________________  
**Name** ______________________________________________________________________  
**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**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. <strong>Do you regularly use a brace, assistive device, or prosthetic?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. <strong>Do you use any special brace or assistive device for sports?</strong></td>
<td></td>
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<tr>
<td>8. <strong>Do you have any rashes, pressure sores, or any other skin problems?</strong></td>
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<tr>
<td>9. <strong>Do you have a hearing loss? Do you use a hearing aid?</strong></td>
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<tr>
<td>10. <strong>Do you have a visual impairment?</strong></td>
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<tr>
<td>11. <strong>Do you use any special devices for bowel or bladder function?</strong></td>
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<tr>
<td>12. <strong>Do you have burning or discomfort when urinating?</strong></td>
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<td>13. <strong>Have you had autonomic dysreflexia?</strong></td>
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<td>14. <strong>Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</strong></td>
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<tr>
<td>15. <strong>Do you have muscle spasticity?</strong></td>
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<tr>
<td>16. <strong>Do you have frequent seizures that cannot be controlled by medication?</strong></td>
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</tbody>
</table>

**Explain “yes” answers here**

---

**Please indicate if you have ever had any of the following.**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Atlantoaxial instability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>X-ray evaluation for atlantoaxial instability</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Dislocated joints (more than one)</strong></td>
<td></td>
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<tr>
<td><strong>Easy bleeding</strong></td>
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<td></td>
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<tr>
<td><strong>Enlarged spleen</strong></td>
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<td></td>
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<tr>
<td><strong>Hepatitis</strong></td>
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<td></td>
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<tr>
<td><strong>Osteopenia or osteoporosis</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Difficulty controlling bowel</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Difficulty controlling bladder</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Numbness or tingling in arms or hands</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Numbness or tingling in legs or feet</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Weakness in arms or hands</strong></td>
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<td></td>
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<tr>
<td><strong>Weakness in legs or feet</strong></td>
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<td></td>
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<tr>
<td><strong>Recent change in coordination</strong></td>
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<td></td>
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<tr>
<td><strong>Recent change in ability to walk</strong></td>
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<td></td>
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<tr>
<td><strong>Spina bifida</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Latex allergy</strong></td>
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<td></td>
</tr>
</tbody>
</table>

**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
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 of exam __________________________
Address __________________________ Phone __________________________
Signature of physician, APN, PA __________________________
# Preparticipation Physical Evaluation CLEARANCE FORM

<table>
<thead>
<tr>
<th>Name ____________________________</th>
<th>Sex ☐ M ☐ F</th>
<th>Age ________________</th>
<th>Date of birth ________________</th>
</tr>
</thead>
</table>

☐ 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 ____________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

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________________________________________________________________________________________________________

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________________________________________________________________________________________________________

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 ____________________________

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