Student’s Name: __________________________ Grade: ________

Circle School Attending in September:

JLHS  JMHS  GOETZ  MCAULIFFE

JACKSON SCHOOL DISTRICT
ATHLETIC DEPARTMENT

PRE-PARTICIPATION
ELIGIBILITY PACKET

Please review all forms for omissions and sign where indicated.

Incomplete forms will result in a delay in eligibility.

Please bring all completed forms to the Nurse’s office of the school your child will attend in September.
INFORMATION ON SCHOOL SPORTS PHYSICALS FOR 2020/2021

- All Student athletes are required to have a current sports physical on file which has been approved by our school physician. Your child will not be allowed to participate in any tryouts and/or practices until all forms have been approved.

- Sports physicals must be submitted on a state approved form and completed by a licensed MD or DO (See “Athletic Physical and Permission Forms Link). Please submit original signed forms to the school nurse – we cannot accept physicals or health history updates via email or fax

- Approved physicals are valid for 365 days from the date of the exam

- If your physical was not completed within 90 days of the start of the season, a Medical History Update form must be completed and submitted (See “Medical History Update Form” Link)

- You may check the status of your child’s physical on the parent portal.

To ensure there is ample time to review and process all private physicals, you must submit your completed physicals to the school nurse at your child’s school no later than:

2020/2021 DUE DATES FOR PRIVATE PHYSICALS:

Fall sports season: August 1, 2020
Winter sports season: October 1, 2020
Spring sports season: February 1, 2021

ANY PHYSICALS HANDED IN AFTER THESE DATES MAY NOT be cleared in time for tryouts.

All physicals must be approved by the school physician as per N.J.A.C. 6A:16-2.2 which 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.

Official Start Dates for High School Athletics:

Fall 2020**
Football and Girls Tennis start on Monday, August 10th
Cross Country, Field Hockey, Soccer, Gymnastics and Girls Volleyball start on Monday, August 17th

Winter 2020/2021
Ice Hockey, Bowling and Swimming start Monday, November 9th
Wrestling, Basketball and Indoor Track start Monday, November 30th
(tryouts 11/23-11/25)

Spring 2021
Golf, Lacrosse and Track start Monday, March 8th
Boys Tennis, Baseball, Softball and Boys Volleyball start Friday, March 12th

**All Fall dates are subject to change due to COVID-19
A Note From Our School Physician

Please use the following checklist to complete the History portion of the Pre-Participation Physical Evaluation and to ensure you are providing us with the information that is required to clear your child to participate in sports. Sport physical approvals will be delayed if information is missing from these forms.

☐ All boxes where "yes" have been checked must have a description in the provided section. Example: If a cardiac related box is checked "yes" explain what the issue is, the relationship to the student, and age of onset etc.

☐ Cardiac History: If your child has ever had a Cardiac History (including as an infant), you must provide clearance from their cardiologist. The clearance note from the treating cardiologist must state that your child is “cleared for competitive sports and gym.”

☐ Vision: If your child's vision is worse than 20/40 you will need a recheck. If there is no improvement on the recheck you must follow up with an optometrist. Please note that your child should wear their prescribed glasses or contacts during the vision exam.

☐ Sport: Remember to indicate which sport(s) your child would like to try out for. If they would like to participate in track, please make sure you specify which season, i.e., Cross Country (Fall), Indoor Track (Winter) or Track & Field (Spring).

Please review all paperwork for omissions before submitting. Common omissions are: blood pressure, vision, height and weight, physician's signature and/or stamp, parent/guardian's signature, student's signature, student's demographic information. These omissions will delay the eligibility process.

Once completed, please submit all forms to the nurse in your child's home school.

Sincerely,

Dr. Thomas Sargent, D.O.
COVID-19 Questionnaire

Name of Student: ____________________________ Date: __________________________

Parent/Guardian Cell: ____________________________ Sport: __________________________

COVID-19 Questions:

Has your son/daughter been diagnosed with Coronavirus (COVID-19)?

- 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.
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 their chart.)

Date of Exam __________________________ Date of birth __________________________

Name __________________________ Age ______ Grade ______ School ______ Sport(s) ______

Medications and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking: __________________________

☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Food ☐ Stinging Insects

Do you have any allergies? __________________________

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS

1. Have you ever been denied or prohibited to participate in sports for any reason? ☐ Yes ☐ No
2. Do you have any ongoing medical conditions? If so, please identify below: Asthma ☐ Arthritis ☐ Aneurysm ☐ 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 heartbeat) during exercise? ☐ Yes ☐ No
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 ☐ A heart rhythm problem ☐ Klinefan disease ☐ Other: __________________________
9. Has a doctor ever ordered a test for your heart? (For example, 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 (including drowning, unexplained car accident, or sudden infant death syndrome)? ☐ Yes ☐ No
14. Does anyone in your family have hyperlipidemia? ☐ 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 you have had an x-ray for neck instability or atlantoaxial instability? (Does your neck hurt or lock?) ☐ Yes ☐ No
22. Do you regularly use a brace, shoes, or other supportive 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, red, warm, or look red? ☐ Yes ☐ No
25. Do you have any history of juvenile arthritis or connective tissue disease? ☐ Yes ☐ No

MEDICAL QUESTIONS

26. Do you cough, wheeze, or have difficulty breathing during or after exercise? ☐ Yes ☐ No
27. Have you ever used an inhaler or taken asthma medicine? ☐ Yes ☐ No
28. Is there anyone in your family who has asthma? ☐ Yes ☐ No
29. Were you born without or are you missing a kidney, an eye, a testicle (male), your spine, or any other organ? ☐ Yes ☐ No
30. Have you had pain in a painful or painful due to injury, although painful? ☐ Yes ☐ No
31. Have you had a positive test for gonorrhea or chlamydia within the last month? ☐ Yes ☐ No
32. Have you had any ear, nose, throat, or skin problems? ☐ Yes ☐ No
33. Have you had a herpes or HSV skin infection? ☐ Yes ☐ No
34. Have you ever had a head injury or concussion? ☐ Yes ☐ No
35. Have you ever had a cut or wound that caused a cut or wound or injury that was not repaired? ☐ Yes ☐ No
36. Have you ever had a surgery or surgery that was not repaired? ☐ Yes ☐ No
37. Have you had headaches with exercise? ☐ Yes ☐ No
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? ☐ Yes ☐ No
39. Have you ever been unable to move your arms or legs after being hit or falling? ☐ Yes ☐ No
40. Have you ever become ill while exercising in the heat? ☐ Yes ☐ No
41. Do you get frequent muscle cramps while exercising? ☐ Yes ☐ No
42. Do you or anyone in your family have sickle cell trait or disease? ☐ Yes ☐ No
43. Have you had any problems with your eyes or vision? ☐ Yes ☐ No
44. Have you had any eye injuries? ☐ Yes ☐ No
45. Do you wear glasses or contact lenses? ☐ Yes ☐ No
46. Do you wear protective eyewear, such as goggles or a face shield? ☐ Yes ☐ No
47. Do you worry about your weight? ☐ Yes ☐ No
48. Are you trying to or has anyone recommended that you gain or lose weight? ☐ Yes ☐ No
49. Are you on a special diet or do you avoid certain types of foods? ☐ Yes ☐ No
50. Have you ever had an eating disorder? ☐ Yes ☐ No
51. Do you have any concerns that you would like to discuss with a doctor? ☐ Yes ☐ No

FEMALES ONLY

52. Have you ever had a menstrual period? ☐ Yes ☐ No
53. How old were you when you had your first menstrual period? ☐ Yes ☐ No
54. How many periods have you had in the last 12 months? ☐ 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 __________________________ Date __________________________
Signature of parent/guardian __________________________ Date __________________________


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

## THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

**ALL PARENTS MUST FILL OUT AND SIGN THIS SECTION (even if all answers are "No")**

<table>
<thead>
<tr>
<th>Date of Exam</th>
<th>Date of birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sports(s)</th>
</tr>
</thead>
</table>

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, etc.)
5. List the sports you are interested in playing

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

6. Do you regularly use a brace, assistive device, or prosthesis?
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 any episodes of diarrhea?
14. Have you ever been diagnosed with a heat-related (hypo/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:

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

**PHYSICAL EXAMINATION FORM**

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of birth</th>
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### PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - Do you feel stressed 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 used alcohol, illegal drugs, or marijuana?
   - During the past 30 days, did you use tobacco, snuff, or dig?
   - 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 medications to help you lose weight or improve your performance?
   - Do you have a heart condition?

2. **Consider reviewing questions on cardiovascular symptoms (questions 5-14)**

### EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
<th>BP</th>
<th>/</th>
<th>( / )</th>
<th>Pulse</th>
<th>Vision</th>
<th>R 20</th>
<th>L 20</th>
<th>Corrected</th>
<th>Y</th>
<th>N</th>
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</table>

### MEDICAL

- Appearances
  - Moth wings, high-arched palate, neck, etc.
  - Redness of the eyes
  - Pupil equal
  - Hearing

### Cardiovascular

- Heart
  - Murmurs (standing, supine, h/P, Tidal)
  - Localization of point of maximal impulse (PMI)

### Pulses

- Simultaneous femoral and radial pulses

### Lungs

- Abdomen
  - Abdominal (palpate only)"

### Skin

- HSV, lesions suggestive of MRSA, lice corporal

### Neurologic

### MUSCULOSKELETAL

- Neck
- Back
- Shoulder/Arm
- Elbow/Forearm
- Wrist/Hands/Fingers
- Hip/Leg
- Knee
- Lumbosacral
- Foot/Ankle

### Functional

- Duck walk, single leg hop

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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 student 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) (initial/initial):**
  - **Date:**

- **Address:**
  - **Signature of physician, APN, PA:**

- **Today's Date:**

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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 ______________

______________________________
______________________________
______________________________
______________________________

HCPC OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on ______________ (Date)
Approved _____ Not Approved _____
Signature: ______________________

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 2016 Pursuant to P.L.2013, c.71
In order for a student to participate in the Jackson School District Athletic Program, all parents and students must acknowledge that they have reviewed and understand various policies, procedures and required authorizations.

These Athletic Participation Consent Forms will be available online on the Jackson School District Parent Portal after your physical is received by the athletic office.

(We receive your physical, and when it is entered into the system, we release the forms to you on the portal. You will see an invitation to fill out the form when you sign on to the portal.)

Similar to the “Back to School” portal signoffs in September, these forms are filled out by signing into the Parent Portal:

https://parents.jacksonsd.org
(a link is also available on all school sites).

Please be sure to fill them out as soon as they are available to you on the portal, so there is no delay in your child being able to participate in the sports program.