Student's Name: _____ Grade in September: _____

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.

Preparticipation Physical Evaluation Medical Eligibility Form

The Medical Eligibility Form is the only form that should be submitted to school. It should be kept on file with the student's school health record.

Student Athlete's Name _____ Date of Birth_____

Date of Exam_____ School_____ Sport_____

- ☐ Medically eligible for all sports without restriction
- ☐ Medically eligible for all sports without restriction with recommendations for further evaluation of treatment of:
- ☐ Medically eligible for certain sports:
- ☐ Not medically eligible pending further evaluation
- ☐ Not medically eligible for any sports

Recommendations: _____

I have reviewed the history form and examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Signature of physician, APN, PA _____ Office Stamp (Optional)

Address: _____

Name of Healthcare professional (print) _____

I certify that I have completed the Cardiac Assessment Professional Development Module developed by the New Jersey Department of Education.

Signature of healthcare provider_____

Shared Health Information

Allergies _____

Medications:

Other information: _____

Emergency Contacts: _____

FOR INTERNAL USE ONLY:

School District Physician Signature _____ Date:_____

RETURN THIS FORM TO THE SCHOOL

Permission to Share Screening Information with the School Nurse (Optional)

The New Jersey Department of Education requires the school nurse to perform annual health screenings on each student every year, including height, weight and blood pressure. Other screenings are required at periodic intervals, including vision, hearing and scoliosis. We can use the data from your child's sports physical to fulfill this requirement if you agree to share it with us. If not, the school nurse will perform the required screenings during the school year.

I give permission to the examining practitioner to share the screening information below with the school nurse.

_____ _____

Signature of parent or guardian Date

IF SIGNED ABOVE, PHYSICIAN FILLS OUT INFORMATION BELOW:

Student's Name _____ Date of Birth _____

Date of exam: _____

Height: _____

Weight: _____

Blood Pressure: _____

Vision: Circle One: Corrected or Uncorrected

Left: _____ Right: _____

Scoliosis: Pass _____

Refer _____

Comments _____

Signature of Provider _____

RETURN THIS FORM TO THE SCHOOL

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student-Athlete Cardiac Assessment Professional Development module hosted by the New Jersey Department of Education.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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■ PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name:_____ Date of birth: _____

1. Type of disability:
2. Date of disability:
3. Classification (if available):
4. Cause of disability (birth, disease, injury, or other):
5. List the sports you are playing:

	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or 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 as having 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 whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (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 questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. 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, e-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-enhancing 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?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N		
Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) _____		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA