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

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 ____________________________________________ 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 _____ Explain “Yes” here ____________________________________________________________

2. Do you have any ongoing medical conditions? If so, please identify below: □ Asthma □ Anemia □ Diabetes □ Infections
   Other: ____________________________________________________________

3. Have you ever had the flu?
   Yes ______ No _____

4. Have you ever had surgery?
   Yes ______ No _____ Explain “Yes” here ____________________________________________________________

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 any 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 YOU

13. Has a heart murmur
    □ Yes ______ No _____

14. Have you ever had a heart murmur
    □ Yes ______ No _____

15. Does a doctor ever have a heart murmur
    □ Yes ______ No _____

16. Do you or someone in your family have a heart murmur
    □ Yes ______ No _____

17. Does anyone in your family have a heart murmur
    □ Yes ______ No _____

18. Are you (or has anyone in your family) taking blood thinners
    □ Yes ______ No _____

19. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

20. Have you ever had a heart murmur
    □ Yes ______ No _____

21. Do you have a heart murmur
    □ Yes ______ No _____

22. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

23. Do you have a heart murmur
    □ Yes ______ No _____

24. Do you have any concerns that you would like to discuss with a doctor?
    □ Yes ______ No _____

25. Have you ever had a heart murmur
    □ Yes ______ No _____

26. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

27. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

28. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

29. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

30. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

31. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

32. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

33. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

34. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

35. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

36. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

37. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

38. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

39. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

40. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

41. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

42. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

43. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

44. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

45. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

46. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

47. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

48. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

49. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

50. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

51. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

52. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

53. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ Yes ______ No _____

54. Are you (or has anyone in your family) on any other medications that may affect your heart
    □ 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 _____

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

HE003

D-2011/0410
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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Do you regularly use a brace, assistive device, or prosthetic?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you use any special brace or assistive device for sports?</td>
<td></td>
<td></td>
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<tr>
<td>8. Do you have any rashes, pressure sores, or any other skin problems?</td>
<td></td>
<td></td>
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<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you have a visual impairment?</td>
<td></td>
<td></td>
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<tr>
<td>11. Do you use any special devices for bowel or bladder function?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Have you had autonomic dysreflexia?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Do you have muscle spasticity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
<td></td>
<td></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>Atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enlarged spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteopenia or osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></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></td>
<td></td>
</tr>
<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spina bifida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex allergy</td>
<td></td>
<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
Preparticipation Physical Evaluation

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 drink alcohol or use any other drugs?
   - Do you wear a seat belt, use a helmet, and use condoms?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Have you ever taken anabolic steroids or used any other performance supplement?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?

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

**PHYSICAL EXAMINATION FORM**

### PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>EXAMINATION</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>L 20/</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### MEDICAL

<table>
<thead>
<tr>
<th>FINDINGS</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperelasticity, myopia, MVP, aortic insufficiency)</td>
</tr>
<tr>
<td>Eyes/ears/nose/throat</td>
<td></td>
<td>Pupils equal</td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td>Murmurs (auscultation standing, supine, +/- Valsalva)</td>
</tr>
<tr>
<td>Pulses</td>
<td></td>
<td>Simultaneous femoral and radial pulses</td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary (males only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td>HSV, lesions suggestive of MRSA, tinea corporis</td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### MUSCULOSKELETAL

<table>
<thead>
<tr>
<th>FINDINGS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td></td>
</tr>
<tr>
<td>Shoulder/arm</td>
<td></td>
</tr>
<tr>
<td>Elbow/forearm</td>
<td></td>
</tr>
<tr>
<td>Wrist/hand/fingers</td>
<td></td>
</tr>
<tr>
<td>Hip/thigh</td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td></td>
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<tr>
<td>Leg/ankle</td>
<td></td>
</tr>
<tr>
<td>Foot/feet</td>
<td></td>
</tr>
<tr>
<td>Functional</td>
<td>Duck-walk, single leg hop</td>
</tr>
</tbody>
</table>

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

Today's Date: __________________________ Date of Exam: __________________________

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 __________________________

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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.