FLHS SPORT PHYSICAL REQUIREMENT PARENT CONSENT

PLEASE READ CAREFULLY & Use Blue or Black Ink Only to Complete the Packet

Student Name: _____ **Grade:** _____

Current Sport: _____ **Date:** _____

Dear Parent(s)/Guardian(s):

Student-athletes who wish to participate in school-sponsored athletic teams must submit the completed Preparticipation Physical Evaluation (PPE) forms to the athletic trainer or school nurse **before** the team's deadline. According to state law, before student-athlete practices or tryouts for a team, all athletic forms must be reviewed and cleared by the Fort Lee School District's off-campus school physician. To ensure that your child is approved to participate in a sports activity, the following items must be submitted:

1. *NJ Department of Education:* **Pre-Participation Physical Evaluation Forms (PPE):**

a) The completion of the NJ Department of Education **Pre-Participation Physical Evaluation Forms (PPE)** which includes: **The History Form, the Athlete with Special Needs: Supplemental History Form, Physical Examination & Clearance Forms** are all required before a student can try out for an athletic sport, participate as student managers, and/or access to the weight room. No other physical examination form, medical note, or prescription will be accepted in place of the current state forms. The physical examination form is only active for one calendar year from the **date of the exam**. After the calendar year expiration date, a new sports physical packet is required and can be submitted **in person only** to the school nurse, the athletic trainer, or the coach. It is recommended that you make a copy of the physical examination & clearance forms and keep it for your records.
Any incomplete areas in the packet will be returned to the student. If an item is not applicable, put N/A and include student and parent signatures. ***Do not separate or discard a page from the packet or it will not be accepted.***

b) The **PPE: Physical Examination & Clearance Forms** **MUST** be completed by a physician (MD/DO), advanced practical nurse (APN), or physician assistant (PA) who has completed the ***Student–Athlete Cardiac Assessment Professional Development Module*** required by the ***Scholastic Student-Athlete Safety Act (SS-ASA) (N.J.S.A 18A:40-41.7)***. It is recommended that you confirm that your medical provider has completed this module **before** scheduling an appointment for a physical exam. The health care provider, who has completed the professional development module is required to ***sign in three designated areas*** specified on the **Physical Examination & Clearance Forms**. Please make sure the **Clearance Form** is stamped on page 6, or it **will not** be accepted. All screenings, including the vision screening (Example: Screening for visual acuity **20/___R 20/ ___L**) must be completed or the forms will be returned to the student. No eyeglass prescriptions will be accepted.

c). If your **healthcare provider is located outside of New Jersey**, the healthcare provider is required by the Fort Lee School District to attach the **Certificate of Completion** to the sports physical packet as part of the statement of assurance for completing the ***Student–Athlete Cardiac Assessment Professional Development Module.*** ***Failure to attach the Certificate of Completion to the sport physical packet will delay the approval process for the student to participate in the sport activity.***

2. **Medical Conditions:**

Students with asthma, severe allergic reactions, diabetes, or other medical conditions are required by state law to have action plans completed **every school year**. These medical forms must be given to the school nurse annually **and are due on the first day of school.** If the medical forms are not submitted, your child will not be able to participate in **any** school-sponsored activities (sports, clubs, and trips). It is recommended that you print out all necessary medical forms before your child attends the scheduled medical appointment. If a reported medical condition has been resolved, the completion of the **Resolution of Medical Condition Form** will be required or a medical note.

➢ *If the healthcare provider makes a referral on the athletic form due to a medical condition, a medical clearance to participate in the sport will be required from the specialist.*

➢ *If there is a documented medical condition on the sports forms, follow-up may be required, along with an updated medical clearance note from the healthcare provider.*
➢ *All emergency medication must be carried by the athlete during practices and games.*
➢ *Epi Pen and Glucagon delegates will be assigned to your child in the event of an emergency.*
➢ *Please note, that Benadryl, antihistamines, and other medications cannot be administered by delegates, the athletic trainer, or coaching staff, only by the school nurse during school hours with completed medical forms.*
➢ *All medication can be given to the school nurse and picked up on the last day of school.*

3. SportsWareOnLine (SWOL) and Sports Educational Fact Sheets:
Parents are required to have a **SportsWareOnLine (SWOL)** account set up for the student-athlete. SWOL can be found at: **www.swol123.net**. Sports participation requires the completion of the **Sports Educational Fact Sheets**, which are available on Genesis under the Parent Portal. For more information please contact the athletic trainer.

4. Athletic Trainer and School Nurse Websites:
All sports physical forms, medical forms, other athletic forms, and consents can be found on the FLHS websites located at:
Athletics website: ***https://flboe.com/administration/athletics_department/athletic_training_room***
School Nurse Website: ***http://flhs.flboe.com/offices/nurse*** located under Athletic Forms and Other Medical Information Forms)

5. Sports Injuries:
Please make sure your child reports any injuries or illnesses to the coach, athletic trainer, and/or school nurse. If your child has an injury during a sports activity, please make sure to submit a doctor's note or a completed, signed, and stamped **Student Medical Report Form** to the Athletic Trainer or School Nurse **before** returning to school and sports activity. The medical note and/or **Student Medical Report Form** must include a return to school clearance date and documentation of any orthopedic and medical devices the student was given to use during school hours. If student accident insurance is needed, you can find the information on the Athletics website.

5. Health History Update Questionnaire:
The Health History Update Questionnaire for student-athletes must be completed every 90 days or before a new seasonal sport (fall, winter, spring) per state law. The update informs us if your child has had any medical problems since the last physical. Explain all "yes" answers on the parent form and a doctor's note may be required for clearance.

7. Parent Initials & Signatures Required:

Parent Initial: _____To ensure the health and safety of my child, I permit my child's medical information to be shared with the Fort Lee School District medical director, school physician, administration, athletic trainer, school nurse, and teacher/coaching staff, as needed.

Parent Initial: _____I understand if my child has an injury during an athletic activity, the athlete must report it to the coach, athletic trainer, and/or school nurse immediately, and must seek further medical evaluation. The **Student Medical Report** form or a medical clearance note, including any medical equipment (for example crutches, orthopedic braces, walking boots, etc.) used to assist the student during school hours must be submitted to the school nurse **before** returning to school.

Parent Initial: _____To ensure the health and safety of the team, please report any illnesses immediately to the coaching staff, athletic trainer, or school nurse. Guidance will be given by the school nurse. A medical clearance note may be required for an illness.

I understand, accept, and agree to comply with all of the sport's physical requirements. I give my child permission to participate in the Fort Lee School District Athletic Program and/or school-sponsored events.

Parent/Guardian Signature: _____
Today's Date: _____

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

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 a 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	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
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?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
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)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
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)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
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)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

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 _____

HE0503 9-2681/0410

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

PREPARTICIPATION PHYSICAL EVALUATION
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

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
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 autonomic dysreflexia?		
14. Have you ever been diagnosed with 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 if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
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 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

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
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, 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 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 (questions 5–14).**

EXAMINATION		
Height _____ Weight _____	☐ Male ☐ Female	
BP ____ / ____ (____ / ____) Pulse _____	Vision R 20/ _____ L 20/ _____	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]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 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 _____

HE0503 9-2681/0410
New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

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 _____

_____

_____

_____

_____

HCP 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 2014; Pursuant to P.L.2013, c.71