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 keepa 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? ⑤ Yes ⑤ No If yes, please identify specific allergy below.

⑤ Medicines ⑤ Pollens ⑤ Food ⑤ Stinging Insects

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

GENERAL QUESTIONS	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: ⑤ Asthma ⑤ Anemia ⑤ Diabetes ⑤ Infections Other: _____	27. Have you ever used an inhaler or taken asthma medicine?		
	28. Is there anyone in your family who has asthma?		
3. Have you ever spent the night in the hospital?	29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
4. Have you ever had surgery?	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes** **No**		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?	31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	32. Do you have any rashes, pressure sores, or other skin problems?		
	33. Have you had a herpes or MRSA skin infection?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?	34. Have you ever had a head injury or concussion?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ⑤ High blood pressure ⑤ A heart murmur ⑤ High cholesterol ⑤ A heart infection ⑤ Kawasaki disease Other: _____	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?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)	38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?	39. Have you ever been unable to move your arms or legs after being hit or falling?		
11. Have you ever had an unexplained seizure?	40. Have you ever become ill while exercising in the heat?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?	41. Do you get frequent muscle cramps when exercising?		
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)?	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?		
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?	45. Do you wear glasses or contact lenses?		
	46. Do you wear protective eyewear, such as goggles or a face shield?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?	47. Do you worry about your weight?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	48. Are you trying to or has anyone recommended that you gain or lose weight?		
BONE AND JOINT QUESTIONS	**Yes** **No**		
	49. Are you on a special diet or do you avoid certain types of foods?		

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			50. Have you ever had an eating disorder?		
18. Have you ever had any broken or fractured bones or dislocated joints?			51. Do you have any concerns that you would like to discuss with a doctor?		
19. Have you ever had an injury that required x-ray, MRI scan, injections, therapy, a brace, a cast, or crutches?			FEMALES ONLY		
20. Have you ever had a stress fracture?			52. Have you ever had a menstrual period?		
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)			53. How old were you when you had your first menstrual period?		
22. Do you regularly use a brace, orthotics, or other assistive device?			54. How many periods have you had in the last 12 months?		
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?					

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		

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.

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_____

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 ⑤ Male ⑤ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ⑤ N ⑤ Y		
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.

⑥ Cleared for all sports without restriction

⑥ Cleared for all sports without restriction with recommendations for further evaluation or treatment for

_____

_____

_____

⑥ Not cleared

⑥ Pending further evaluation

⑥ For any sports

⑥ 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 andI 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**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 condi**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**tions 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).
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

_____

PreparticipationPhysicalEvaluation CLEARANCEFORM

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_____