

**MANASQUAN BOARD OF EDUCATION  
169 BROAD STREET  
MANASQUAN, NJ 08736**

**REQUEST FOR PROPOSAL**

The Manasquan School District is seeking proposals for Professional Services – District/Sports Medical Physician. Specifications are available through Lynn Coates, School Business Administrator/Board Secretary, 169 Broad Street, Manasquan, NJ 08736, 732.528.8803 ext. 1921. Proposals are due in the business office by 10:00 a.m. on Friday, December 7, 2018.

**SPECIFICATIONS**

All proposals shall be subject to the provisions of section 1 of P.L. 1977, c.33 (C.52:25-24.2) requiring submission of a statement of corporate ownership.

All Proposals shall be subject to the provisions of P.L. 1975, c.127 (C.10:5-31 et seq.) concerning equal employment opportunity and affirmative action.

All proposals shall be subject to the provisions of N.J.S.A. 19:44A-20.26 concerning political contribution disclosure.

All proposals shall be subject to the provisions of N.J.S.A. 52:32-44 concerning business registration certificates.

**Contract Period:** January 1, 2019 – December 31, 2019

**Annual Fee:**

Annual Fee will be paid through the receipt of monthly invoices processed after approval by the board at their monthly meetings.

**Tools, Equipment, Miscellaneous:**

The District/Sports Medical Physician shall provide the tools and equipment necessary for the provision of his/her services. The District/Sports Medical Physician shall possess a medical license valid in the State of New Jersey with all the certifications necessary to perform the duties described. The District/Sports Medical Physician shall maintain in full force and effect, malpractice insurance in the amount of \$1,000,000/\$3,000,000. The District/Sports Medical Physician shall perform all services with a degree of confidence acceptable in standard medical practice.

### **Medical Services:**

The District/Sports Medical Physician will perform the following services annually on a mutually agreed upon schedule:

- Perform physicals on any students whose parents are indigent and without insurance.
- Consult with the school nurse regarding the administration of medication and sign medication orders from private physicians.
- Write prescriptions for the school district's stock epinephrine injections and glucagon injections
- Assesses medical requests for Home Instruction.
- Acts as a resource person for questions and information involving disease states, diagnoses, assessments, evaluation, treatment options and at times, legal issues.
- Reports to the district to approve all sports physicals at the direction and scheduling of the school administration or designee.
- Reviews and implements district policy regarding concussion management, including re-entry to sports and physical education; classroom and educational re-entry, academic accommodations, and make-up of missed work; and home schooling when necessary and appropriate.
- Reviews, approves and submits standing orders for school nurses and the athletic trainer every year.
- Participates in case conferences with the child study team, as requested.
- Responds to emergency medical calls related to injuries, illness or suspected substance abuse.
- Available to consult with school nurse on issues related to the school health program.
- Performs other duties within the scope of certification and contractual agreement.

**DISTRICT/SPORTS MEDICAL PHYSICIAN**  
**MANASQUAN BOARD OF EDUCATION**

**NAME** \_\_\_\_\_

**DATE** \_\_\_\_\_

**SUBMITTED BY:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**Annual Fee Proposed: \$** \_\_\_\_\_

The services indicated are those that will be in effect for the duration of the Contract.

1. Please list any other services or proposals that would be offered. If there are conditions or charges, please state them:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Describe any variations from the required services listed in the Request for Proposal below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **SUBMISSION OF RFP PACKAGE:**

All RFP Proposal Packages are to be submitted to:

Lynn Coates  
School Business Administrator/Board Secretary  
Manasquan Board of Education  
169 Broad Street  
Manasquan, NJ 08736

Respondents are to include:

- One original **RFP** Package with original signature
- One copy of the **RFP** Package.

### **SUBMISSION DEADLINE**

The deadline to submit all **RFP** Packages is **Friday, December 7, 2018** on or before **10:00 a.m.**

### **AWARD OF CONTRACT:**

It is the intention of the Board of Education to award the contract to the respondent based upon relative experience, qualifications, and who will provide the highest quality of service at fair and competitive prices.

### **AUTHORIZATION TO WORK:**

No service shall be rendered unless the successful respondent receives an approved purchase order authorizing the respondent to render the service.

### **DOCUMENTS TO BE SUBMITTED WITH THE PROPOSAL:**

- Affirmative Action Questionnaire
- Stockholders Disclosure Statement
- Disclosure of Investment Activities in Iran
- Vendor Questionnaire/Certification
- New Jersey Business Registration Certificate
- Chapter 271 Political Contribution Disclosure Form
- Non-Collusion Affidavit
- W-9



**STOCKHOLDER OR PARTNERSHIP DISCLOSURE AFFIDAVIT**

In accordance with the Instructions to Bidders and the provisions of Chapter 33, Public Laws of 1977, State of New Jersey, N.J. S. A. 52:25-24.1, the undersigned hereby certifies the following Stockholder or Partnership information as complete and accurate:

**Stockholders or Partners Owning 10% or More of the Company Submitting Bid**

---

Name of Stockholder/Partner	Address
-----------------------------	---------

---

Name of Stockholder/Partner	Address
-----------------------------	---------

---

Name of Stockholder/Partner	Address
-----------------------------	---------

---

Name of Stockholder/Partner	Address
-----------------------------	---------

Use other side for other stockholders/partners.

\_\_\_\_ No individual stockholder or partner owns ten percent (10%) or more of this corporation or partnership.

---

Name of Contractor	Address
--------------------	---------

By: \_\_\_\_\_  
(Print Name and Official Title)

Signature: \_\_\_\_\_

State of \_\_\_\_\_ }

} SS

County of \_\_\_\_\_ }

Before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Notary Public \_\_\_\_\_

**THIS FORM MUST BE COMPLETED, SIGNED, AND SUBMITTED WITH RFP.**

STATE OF NEW JERSEY -- DIVISION OF PURCHASE AND PROPERTY  
DISCLOSURE OF INVESTMENT ACTIVITIES IN IRAN

Quote Number: \_\_\_\_\_

Bidder/Offeror: \_\_\_\_\_

**PART 1: CERTIFICATION**

**BIDDERS MUST COMPLETE PART 1 BY CHECKING EITHER BOX.**

**FAILURE TO CHECK ONE OF THE BOXES WILL RENDER THE PROPOSAL NON-RESPONSIVE.**

Pursuant to Public Law 2012, c. 25, any person or entity that submits a bid or proposal or otherwise proposes to enter into or renew a contract must complete the certification below to attest, under penalty of perjury, that neither the person or entity, nor any of its parents, subsidiaries, or affiliates, is identified on the Department of Treasury's Chapter 25 list as a person or entity engaging in investment activities in Iran. The Chapter 25 list is found on the Division's website at <http://www.state.nj.us/treasury/purchase/pdf/Chapter25List.pdf>. Bidders must review this list prior to completing the below certification. **Failure to complete the certification will render a bidder's proposal non-responsive.** If the Director finds a person or entity to be in violation of law, s/he shall take action as may be appropriate and provided by law, rule or contract, including but not limited to, imposing sanctions, seeking compliance, recovering damages, declaring the party in default and seeking debarment or suspension of the party

**PLEASE CHECK THE APPROPRIATE BOX:**

I certify, pursuant to Public Law 2012, c. 25, that neither the bidder listed above nor any of the bidder's parents, subsidiaries, or affiliates is listed on the N.J. Department of the Treasury's list of entities determined to be engaged in prohibited activities in Iran pursuant to P.L. 2012, c. 25 ("Chapter 25 List"). I further certify that I am the person listed above, or I am an officer or representative of the entity listed above and am authorized to make this certification on its behalf. I will skip Part 2 and sign and complete the Certification below.

OR

I am unable to certify as above because the bidder and/or one or more of its parents, subsidiaries, or affiliates is listed on the Department's Chapter 25 list. I will provide a detailed, accurate and precise description of the activities in Part 2 below and sign and complete the Certification below. Failure to provide such will result in the proposal being rendered as non-responsive and appropriate penalties, fines and/or sanctions will be assessed as provided by law.

**PART 2: PLEASE PROVIDE FURTHER INFORMATION RELATED TO INVESTMENT ACTIVITIES IN IRAN**

You must provide a detailed, accurate and precise description of the activities of the bidding person/entity, or one of its parents, subsidiaries or affiliates, engaging in the investment activities in Iran outlined above by completing the boxes below.

**EACH BOX WILL PROMPT YOU TO PROVIDE INFORMATION RELATIVE TO THE ABOVE QUESTIONS. PLEASE PROVIDE THOROUGH ANSWERS TO EACH QUESTION. IF YOU NEED TO MAKE ADDITIONAL ENTRIES, CLICK THE "ADD AN ADDITIONAL ACTIVITIES ENTRY" BUTTON.**

Name _____	Relationship to Bidder/Offeror _____
Description of Activities _____ _____	
Duration of Engagement _____	Anticipated Cessation Date _____
Bidder/Offeror Contact Name _____	Contact Phone Number _____

ADD AN ADDITIONAL ACTIVITIES ENTRY

Certification: I, being duly sworn upon my oath, hereby represent and state that the foregoing information and any attachments thereto to the best of my knowledge are true and complete. I attest that I am authorized to execute this certification on behalf of the above-referenced person or entity. I acknowledge that the State of New Jersey is relying on the information contained herein and thereby acknowledge that I am under a continuing obligation from the date of this certification through the completion of any contracts with the State to notify the State in writing of any changes to the answers of information contained herein. I acknowledge that I am aware that it is a criminal offense to make a false statement or misrepresentation in this certification, and if I do so, I recognize that I am subject to criminal prosecution under the law and that it will also constitute a material breach of my agreement(s) with the State of New Jersey and that the State at its option may declare any contract(s) resulting from this certification void and unenforceable.

Full Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**Vendor Questionnaire/Certification**

Name of Company \_\_\_\_\_  
Street Address \_\_\_\_\_ PO Box \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Business Phone Number \_\_\_\_\_ Ext. \_\_\_\_\_  
Emergency Phone Number \_\_\_\_\_  
FAX No. \_\_\_\_\_ E-Mail \_\_\_\_\_  
Years in Business \_\_\_\_\_ Number of Employees \_\_\_\_\_

References- Work previously done for School Systems in New Jersey

Name of District	Address	Contact Person/Title	Phone
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

**Vendor Certification**

**Direct/Indirect Interests**

I declare and certify that no member of the Manasquan Board of Education, nor any officer or employee or person whose salary is payable in whole or in part by said Board of Education or their immediate family members are directly or indirectly interested in this bid or in the supplies, materials, equipment, work or services to which it relates, or in any portion of profits thereof. If a situation so exists where a Board member, employee, officer of the board has an interest in the bid, etc., then please attach a letter of explanation to this document, duly signed by the president of the firm or company.

**Gifts; Gratuities; Compensation**

I declare and certify that no person from my firm, business, corporation, association or partnership offered or paid any fee, commission or compensation, or offered any gift, gratuity or other thing of value to any school official, board member or employee of the Manasquan Board of Education.

Vendor Contributions

I declare and certify that I fully understand N.J.A.C. 6A:23A-6.3(al-4) Concerning vendor contributions to school board members.

I certify that I am not an official or employee of the Manasquan Board of Education.

I further certify that I understand that it is a crime in the second degree in New Jersey to knowingly make a material representation that is false in connection with the negotiation, award or performance of a government contract.

\_\_\_\_\_  
President or Authorized Agent



# C. 271 POLITICAL CONTRIBUTION DISCLOSURE FORM

Required Pursuant To N.J.S.A. 19:44A-20.26

This form or its permitted facsimile must be submitted to the local unit no later than 10 days prior to the award of the contract.

## Part I – Vendor Information

Vendor Name:			
Address:			
City:	State:	Zip:	

The undersigned being authorized to certify, hereby certifies that the submission provided herein represents compliance with the provisions of N.J.S.A. 19:44A-20.26 and as represented by the Instructions accompanying this form.

Signature

Printed Name

Title

## Part II – Contribution Disclosure

Disclosure requirement: Pursuant to N.J.S.A. 19:44A-20.26 this disclosure must include all reportable political contributions (more than \$300 per election cycle) over the 12 months prior to submission to the committees of the government entities listed on the form provided by the local unit.

Check here if disclosure is provided in electronic form.

Contributor Name	Recipient Name	Date	Dollar \$

Check here if the information is continued on subsequent page(s)



NON-COLLUSION AFFIDAVIT

STATE OF NEW JERSEY }
COUNTY OF MONMOUTH } SS
(Name of Bid/Project)

I, \_\_\_\_\_, of the \_\_\_\_\_ of
\_\_\_\_\_, in the County of \_\_\_\_\_,

State of \_\_\_\_\_, of full age, being duly sworn according to law on my
oath depose and say that:

I am \_\_\_\_\_ of the firm of \_\_\_\_\_,
the bidder making the proposal for the above named project; that I executed the said Proposal
with full authority to do so; that said bidder has not, directly or indirectly, entered into any
agreement, participated in any collusion, or otherwise taken any action in restraint of free,
competitive bidding in connection with the above named project; and that all statements
contained in said Proposal and in this affidavit are true and correct, and made with full
knowledge that the State of New Jersey relies upon the truth of the statements contained in said
Proposal and in the statements contained in this affidavit in awarding the contract for said
project.

I further warrant that no person or selling agency has been employed or retained to solicit or
secure such contract upon an agreement or understanding for a percentage, commission,
brokerage or contingent fee, except bona fide employees or bona fide established commercial or
selling agencies maintained by \_\_\_\_\_ in accordance with N.J.S.A
52:32.15 (Name of Contractor)

Subscribed and sworn before me this
\_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_ (Affiant's Signature)

(Seal) Notary Public of New Jersey (Print Affiant's Name)
\_\_\_\_\_

My Commission expires \_\_\_\_\_, 20 \_\_\_\_\_

THIS FORM MUST BE COMPLETED, SIGNED, AND SUBMITTED WITH RFP.

## C. 271 POLITICAL CONTRIBUTION DISCLOSURE FORM

### Contractor Instructions

Business entities (contractors) receiving contracts from a public agency that are NOT awarded pursuant to a "fair and open" process (defined at N.J.S.A. 19:44A-20.7) are subject to the provisions of P.L. 2005, c. 271, s.2 (N.J.S.A. 19:44A-20.26). This law provides that 10 days prior to the award of such a contract, the contractor shall disclose contributions to:

- any State, county, or municipal committee of a political party
- any legislative leadership committee
- any continuing political committee (a.k.a., political action committee)
- any candidate committee of a candidate for, or holder of, an elective office:
  - o of the public entity awarding the contract
  - o of that county in which that public entity is located
  - o of another public entity within that county
  - o or of a legislative district in which that public entity is located or, when the public entity is a county, of any legislative district which includes all or part of the county

The disclosure must list reportable contributions to any of the committees that exceed \$300 per election cycle that were made during the 12 months prior to award of the contract. See N.J.S.A.

19:44A-8 and 19:44A-16 for more details on reportable contributions.

N.J.S.A. 19:44A-20.26 itemizes the parties from whom contributions must be disclosed when a business entity is not a natural person. This includes the following:

- individuals with an "interest" ownership or control of more than 10% of the profits or assets of a business entity or 10% of the stock in the case of a business entity that is a corporation for profit
- all principals, partners, officers, or directors of the business entity or their spouses
- any subsidiaries directly or indirectly controlled by the business entity
- IRS Code Section 527 New Jersey based organizations, directly or indirectly controlled by the business entity and filing as continuing political committees, (PACs).

When the business entity is a natural person, "a contribution by that person's spouse or child, residing therewith, shall be deemed to be a contribution by the business entity."

[N.J.S.A.

19:44A-20.26(b)] The contributor must be listed on the disclosure.

Any business entity that fails to comply with the disclosure provisions shall be subject to a fine imposed by ELEC in an amount to be determined by the Commission which may be based upon the amount that the business entity failed to report.

The enclosed list of agencies is provided to assist the contractor in identifying those public agencies whose elected official and/or candidate campaign committees are affected by the disclosure requirement. It is the contractor's responsibility to identify the specific committees to which contributions may have been made and need to be disclosed. The disclosed information may exceed the minimum requirement.

The enclosed form, a content-consistent facsimile, or an electronic data file containing the required details (along with a signed cover sheet) may be used as the contractor's submission and is disclosable to the public under the Open Public Records Act.

- N.J.S.A. 19:44A-3(s): "The term "legislative leadership committee" means a committee established, authorized to be established, or designated by the President of the Senate, the Minority Leader of the Senate, the Speaker of the General Assembly or the Minority Leader of the General Assembly pursuant to section 16 of P.L.1993, c.65 (C.19:44A-10.1) for the purpose of receiving contributions and making expenditures."

**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 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	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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
<b>HEART HEALTH QUESTIONS ABOUT YOU</b>	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
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?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
<b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 60 (including drowning, unexplained car accident, or sudden infant death syndrome)?			40. Have you ever become ill while exercising in the heat?		
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?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
<b>BONE AND JOINT QUESTIONS</b>	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
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)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			<b>FEMALE ONLY</b>		
25. Do you have any history of juvenile arthritis or connective tissue disease?			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 \_\_\_\_\_

© 2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

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

8-3981/04.10

# ■ 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		
K-MY 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 \_\_\_\_\_

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.  
New Jersey Department of Education 2014; Pursuant to P.L. 2013, c. 71

**NOTE:** The preparticipation 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

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

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP	/	( / )	Pulse Vision R 20/ L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
NEURAL	HEALTHY	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* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (male only)			
Skin • HSV lesions suggestive of MRSA, three corpora			
Neurologic*			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

\*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 exams 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 \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Signature of physician, APN, PA \_\_\_\_\_



# ■ 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 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### NCP 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 \_\_\_\_\_

© 2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment. New Jersey Department of Education 2014; Pursuant to P.L. 2013, c. 71