MANASQUAN HIGH SCHOOL
Department of Athletics

Mr. Peter Cahill, *Supervisor of Athletics/Extra-Curricular Activities*
732-528-8820 Ext. 1022
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FULL SPORTS PHYSICAL EVALUATION PACKET

COMPLETE THE FOLLOWING PACKET IF THE STUDENT-ATHLETE'S LAST PHYSICAL EXAM WAS **MORE THAN 365 DAYS** FROM THE FIRST DAY OF PRACTICE.

THERE ARE **TWO PARTS** TO MANASQUAN HIGH SCHOOL'S ATHLETICS APPLICATION:

ONLINE:

Visit the Genesis Parent Portal and select the *"Forms"* tab. You will see an application specific to the sports season available. This application can only be completed once per student-athlete per season. The following components are to be completed online:

1. SPORTS APPLICATION AND AGREEMENT
2. NJSIAA STEROID TESTING POLICY
3. NJSIAA CONCUSSION POLICY
4. NJSIAA SUDDEN CARDIAC DEATH POLICY
5. NJSIAA OPIOID POLICY
6. EMERGENCY CONTACT INFORMATION

PAPER:

All students planning to participate in sports must have one comprehensive sport physical per year. According to the N.J.A.C. 6A:16-2.2 et.seq. each candidate for a school athletic team must have a medical examination within 365 days prior to the first practice session and a health history update within 90 days of the first practice session. The forms within this packet, provided by Manasquan and the NJSIAA, must be used. No substitutes, such as doctor's notes or other physical forms are acceptable. Physical evaluations must be completed and signed by a physician licensed to practice medicine (MD, DO) a Nurse Practitioner or Physician's Assistant working with a physician. If you have corrective lenses, bring them with you as a vision exam is required for sports participation.

1. HISTORY FORM (Signed by student and parent/guardian)
2. THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM (Signed by student and parent/guardian)
3. PHYSICAL EXAMINATION FORM (Signed by physician)
4. CLEARANCE FORM (Signed by physician. Be sure physician has also signed off that the Cardiac Assessment Professional Development Module has been completed)
5. AUTHORIZATION FOR MEDICATION (Signed by parent/guardian and medical provider)
6. HEALTH HISTORY UPDATE FORM (Signed by parent/guardian)

Once completed and signed appropriately, this entire paper portion must be submitted to the Health Office mailbox in the main office to be considered for sports participation. The school nurse and school physician will then evaluate the examination and notification will then be sent to the parent/guardian. Any omissions may delay the pre-participation process.

YOU MAY CHECK YOUR STUDENT'S CLEARANCE STATUS ON GENESIS UNDER THE "ATHLETICS" TAB.

If you have any questions regarding these instructions, direct them toward:
Director of Athletics at Manasquan High School: 732-528-8820 x 1022

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

To be completed and signed by athlete and parent/guardian

(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 _____

SIGN HERE

PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

To be completed and signed by athlete and parent/guardian

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 _____

SIGN HERE

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).**

To be completed and signed by school or private physician

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 _____ SIGN HERE

HE0503 9-2681/0410

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

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

To be completed and signed by school or private physician

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 _____ SIGN HERE

Completed Cardiac Assessment Professional Development Module

Date_____ Signature_____ SIGN HERE

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

MANASQUAN HIGH SCHOOL

"EDUCATION FOR EXCELLENCE"

Cheryl Bontales, School Nurse
167 Broad Street
Manasquan, NJ 08736
tel: 732-528-8820 ext. 6
fax: 732-528-5114
email: cbontales@manasquanboe.org

To: Parent/Guardian

From: School Nurse

RE: Medications in school

If your child's medical condition requires the administration of medication during school hours, or during after school sports, the information must be provided on the form that appears on the reverse side of this letter. (Please make copies as needed)

The form must be completed and signed by you and your physician and returned to the school nurse with the medication in the pharmacy's labeled container. Medication will not be dispensed unless it is prescribed, and in its original labeled container.

Students living with Diabetes and on Insulin must provide this form for both the Insulin and Glucagon the student carries. Students living with Asthma or exercise induced Asthma must provide this form in order to carry the inhaler or nebulizer. Students at risk for anaphylactic reaction due to bee stings or food allergy must provide this form with Epinephrine Injection.

Failure to complete this form may delay the sports preparticipation process, especially if a delegate has to be trained and assigned for the administration of the medication for your student.

It is illegal for any student to carry medication or dispense medication without the health office's knowledge and the accompanying form fully completed

If you have any questions, please contact the school nurse.

MANASQUAN SCHOOL DISTRICT

SCHOOL HEALTH SERVICES PROGRAM

If needed, to be completed and signed by parent/guardian and private physician

Authorization for Medication

If medication is to be taken during school or school sponsored activities, complete this form.

A. This section to be completed by the parent or guardian

Student's Name: _____ Date of Birth: _____

Home Address: _____ Gender: _____ Grade _____

Physician: _____

Physician's Address: _____ Telephone #: _____

_____ I request that my child be assisted in taking the medicine(s) described below at school, by legally authorized persons.

_____ I request that my child be permitted to self-administer the medicine(s), *for a life threatening illness**, both which are described below.

*Life-threatening illness means an illness or condition that requires an immediate response to specific symptoms or sequelae that if left untreated may lead to potential loss of life such as, but not limited to, the use of an inhaler to treat an asthma attack or the use of an adrenalin injection to treat a potential anaphylactic reaction.

Parent's/Guardian's Name (please print): _____

Home Telephone #: _____ Emergency #: _____

B. This section to be completed by the physician

Name of medicine(s)	
Form (tabs, caps, inj., etc)	
Dose	
If prescribed daily, what time?	
If prescribed "PRN" describe indications.	
How soon can the medication dose be repeated?	
List significant side effects.	
Is this medication for a life threatening illness?	
Is the child authorized to self-administer the medication?	
Has the child been trained by the physician?	
Length of time this treatment is recommended?	
Other information or concerns	

Medical Provider's Signature: _____ Date: _____ SIGN HERE

Waiver of Liability

The Manasquan Board of Education hereby informs the parents of the above student that the district shall not incur liability as a result of any injury from self-medication. I hereby sign that I have read the above statement and will hold the Manasquan Board of Education harmless against any injury or claims that arise as a result of my child's self administration.

Parent's/Guardian's Signature: _____ Date: _____ SIGN HERE

School Physician's Signature: _____ Date: _____

State of New Jersey
DEPARTMENT OF EDUCATION

To be completed and signed by parent/guardian

HEALTH HISTORY UPDATE QUESTIONNAIRE

Name of School _____

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student's parent or guardian.

Student _____ **Age**_____ **Grade** _____

Date of Last Physical Examination_____ **Sport**_____

Since the last pre-participation physical examination, has your son/daughter:

1. Been medically advised not to participate in a sport? Yes____ No____
   If yes, describe in detail _____
   _____
   _____
2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes____ No____
   If yes, explain in detail _____
   _____
   _____
3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes____ No____
   If yes, describe in detail _____
   _____
   _____
4. Fainted or "blacked out?" Yes____ No____
   If yes, was this during or immediately after exercise?_____
   _____
   _____
5. Experienced chest pains, shortness of breath or "racing heart?" Yes____ No____
   If yes, explain _____
   _____
6. Has there been a recent history of fatigue and unusual tiredness? Yes____ No____
7. Been hospitalized or had to go to the emergency room? Yes____ No____
   If yes, explain in detail _____
   _____
   _____
8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes____ No____
9. Started or stopped taking any over-the-counter or prescribed medications? Yes____ No____
   If yes, name of medication(s)_____
   _____

Date:_____ **Signature of parent/guardian** _____ SIGN HERE

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE'S OFFICE