

## FULL 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 SCHOOL DISTRICT'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. HEALTH HISTORY UPDATE QUESTIONS
3. NJSIAA STEROID TESTING POLICY
4. NJSIAA CONCUSSION POLICY
5. NJSIAA SUDDEN CARDIAC DEATH POLICY
6. NJSIAA OPIOID POLICY
7. 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. 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 (If needed, signed by parent/guardian and medical provider)

**Once completed and signed appropriately, this paper portion must be submitted to the Health Office to be considered for sports participation.** All medical paperwork must be handed in, in its original form. Paperwork sent by email or fax will not be accepted. The school nurse and school physician will then evaluate the examination. Any omissions may delay the pre-participation process. Please allow for one-week for physical examination approval by the school physician.

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:

Manasquan School District Athletics Office: 732-528-8820 x1022

**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	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>	<b>Yes</b>	<b>No</b>	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>	<b>Yes</b>	<b>No</b>	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 50 (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>	<b>Yes</b>	<b>No</b>	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>FEMALES 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**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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		
	<b>Yes</b>	<b>No</b>
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

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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

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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**

**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).

To be completed and signed by  
school or private physician

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
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li> </ul>		
Eyes/ears/nose/throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, supine, +/- Valsalva)</li> <li>Location of point of maximal impulse (PMI)</li> </ul>		
Pulses <ul style="list-style-type: none"> <li>Simultaneous femoral and radial pulses</li> </ul>		
Lungs		
Abdomen		
Genitourinary (males only) <sup>b</sup>		
Skin <ul style="list-style-type: none"> <li>HSV, lesions suggestive of MRSA, tinea corporis</li> </ul>		
Neurologic <sup>c</sup>		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional <ul style="list-style-type: none"> <li>Duck-walk, single leg hop</li> </ul>		

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.

<sup>c</sup>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

# 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

## PROCEDURE FOR ADMINISTRATION OF MEDICATION



Prior to the School Nurses administering any medication, the health office shall have on file a **Medication Authorization Form** for the involved student, prepared by the student's attending licensed prescriber in compliance with the Manasquan School District's procedures, and signed by the student's parent/guardian.

Whenever possible, the parent/guardian should plan for medication to be administered at home, before and/or after school hours. In situations when a student's health could be compromised by not receiving medication during school hours, school district procedures must be followed for administering all medications.

1. Medication is defined as prescription or non-prescription (over the counter) drugs, including vitamins and supplements.
2. Administration of any medication requires both a physician's written order and signed parental permission.
3. Prescription medication must be in a pharmacy or physician labeled container. Over the counter medication must in its original container, sealed and unopened with the manufacturers label, clearly marked with the student's name.
4. It is the parent's/guardian's responsibility to bring the medication to school.
5. All medications to be taken during school hours will be kept in the School Nurse's office. It is the responsibility of the student to report to the nurse's office at the proper time to receive his/her medication. Students are allowed to carry and self-administer asthma medication or may use an Epinephrine Auto-Injector for anaphylaxis only after the school is notified, the student's parent/guardian and physician have signed the Medication Authorization Form, and it has been approved by our School Physician.
6. The parent/guardian must assume responsibility for informing the school, in writing, of any change in the student's health or change in medication. A physician's order must accompany any medication change.
7. Medication must be picked up by a parent/guardian on or before the last day of school. Medication not picked up will be discarded. Medication authorization is to be renewed, if necessary, every school year.
8. The school district cannot dispense medication without the completed Medication Authorization Form received, reviewed, and approved. It is wise to have it completed and mailed to the Office of the School Nurse in August for the upcoming school year.

**Please note: Any missing information on the Medication Authorization Form will render it incomplete and it will be returned to the parent/guardian for correction, which may delay implementation of a pharmacological treatment plan**

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



# MANASQUAN SCHOOL DISTRICT

## MEDICATION AUTHORIZATION FORM

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Grade: \_\_\_\_\_ Gender: \_\_\_\_\_ Home Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Contact #: \_\_\_\_\_

I (we) request authorization and consent to have the school nurse administer medication to my child, while in school, as prescribed by our private physician. The Manasquan BOE hereby informs the parents of the above child 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 MBOE harmless against any injury or claims that arise as a result of my child's self-administration.

Signed \_\_\_\_\_ Date \_\_\_\_\_

SIGN HERE

### TO BE FILLED OUT BY PHYSICIAN

Diagnosis: \_\_\_\_\_ Name of Medication: \_\_\_\_\_

Dosage, Form & Time: \_\_\_\_\_

If given prn, describe indications: \_\_\_\_\_ When can it be repeated? \_\_\_\_\_

Significant side effects include: \_\_\_\_\_

Is this medication for a life-threatening illness? \_\_\_\_\_ Is the child authorized to self-administer? \_\_\_\_\_

Has the child been trained by the healthcare provider? \_\_\_\_\_

Length of time this order is valid (may NOT exceed school year): \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Stamp:

### APPROVAL OF SCHOOL PHYSICIAN

I have reviewed the above request and authorize the school nurse to administer the prescribed medication as ordered during school hours.

School Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_

SIGN HERE