ATTENTION PARENT/GUARDIAN: The preparticlaption 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

ame			Date of birth		
ex Age Grade Sch	ool		Sport(s)		
Medicines and Allergies: Please list all of the prescription and over	-the-co	unter m	edicines and supplements (herbal and nutritional) that you are currently	taking	
				1	
De vers have any effective C. El Ver. El New York States Idea		-181M			_
Do you have any allergies? ☐ Yes ☐ No If yes, please ider ☐ Medicines ☐ Pollens	nury spe		ergy below.  ☐ Food ☐ Stinging Insects		
xplain "Yes" answers below. Circle questions you don't know the an	swers t	o.			
GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
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			27. Have you ever used an Inhaler or taken asthma medicine?		
below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other:			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 spieen, 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	31. Have you had infectious mononucleosis (mono) within the last month?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		-
6. Have you ever had discomfort, pain, tightness, or pressure in your			Rave you had a herpes or MRSA skin infection?  34. Have you ever had a head injury or concussion?		
chest during exercise?			35. Have you ever had a hit or blow to the head that caused confusion,		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			prolonged headache, or memory problems?		
Has a doctor ever told you that you have any heart problems? If so, check all that apply:			36. Do you have a history of seizure disorder?		
☐ High blood pressure ☐ A heart murmur			37. Do you have headaches with exercise?		_
☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other:			38. Have you ever had numbness, tingling, or weakness in your arms or tegs after being hit or falling?		
Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			39. Have you ever been unable to move your arms or legs after being hit or falling?		
iO. Do you get lightheaded or feel more short of breath than expected			40. Have you ever become III while exercising in the heat?		
during exercise?			41. Do you get frequent muscle cramps when exercising?		_
Have you ever had an unexplained seizure?     Do you get more tired or short of breath more quickly than your friends			42. Do you or someone in your family have sickle cell trait or disease?		
during exercise?			43. Have you had any problems with your eyes or vision?  44. Have you had any eye injuries?		-
EART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact tenses?		<del>                                     </del>
3. Has any family member or relative died of heart problems or had an			46. Do you wear protective eyewear, such as goggles or a face shield?		-
unexpected or unexplained sudden death before age 50 (Including drowning, unexplained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight?		
Does anyone in your family have hypertrophic cardiomyopathy, Martan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT			48. Are you trying to or has anyone recommended that you gain or loss weight?		
syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic			49. Are you on a special diet or do you avoid certain types of foods?		
polymorphic ventricular tachycardia?			50. Have you ever had an eating disorder?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?		
6. Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY		4.3
seizures, or near drowning?  NONE AND JOINT QUESTIONS	Yes	No	52. Have you ever had a menstrual period?     53. How old were you when you had your first menstrual period?		
7. Have you ever had an injury to a bone, muscle, figament, or tendon	10.8	100	54. How many periods have you had in the last 12 months?		
that caused you to miss a practice or a game?			Explain "yes" answers here		
8. Have you ever had any broken or fractured bones or dislocated joints?			and the second s		
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?					
O. 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?				91	
4. Do any of your joints become painful, swollen, feel warm, or look red?					
cr. do mil or jour journe become planning arrending root training or training					

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## PREPARTICIPATION PHYSICAL EVALUATION

# THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam				
Name			Date of birth	
Sex Age	Grade	School	Sport(s)	
Type of disability				
2. Date of disability				
3. Classification (if available)				
	isease, accident/trauma, other)	1 27		
5. List the sports you are inte				<u> </u>
			Yes	* No
	ce, assistive device, or prosthet			
	ice or assistive device for sport			
B. Do you have any rashes, pr	ressure 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 impai	rment?			
11. Do you use any special dev	rices for bowel or bladder funct	don?		
12. Do you have burning or dis	comfort when urinating?			
13. Have you had autonomic d				
14. Have you ever been diagno	sed with a heat-related (hyperi	thermia) or cold-related (hypothermia) itines	s?	
15. Do you have muscle spasti	<u>.*</u>			
16. Do you have frequent seizu	res that cannot be controlled b	y medication?		
Please indicate if you have eve	er had any of the following.		Yes	No
Atlantoaxial instability			Yes	No No
Atlantoaxial instability X-ray evaluation for atlantoaxial	Instability		Yes	s No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one	Instability		Yes	s No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding	Instability		Yes	s No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spleen	Instability		Yes	i No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis	Instability		Yes	No No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis	Instability		Yes	No.
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel	Instability		Yes	No.
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder	Instability		Yes	No.
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or	Instability a) hands		Yes	No.
Attantoaxial instability X-ray evaluation for attantoaxial 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 Numbness or tingling in legs or	Instability a) hands		Yes	No
Attantoaxial instability X-ray evaluation for attantoaxial 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 Numbness or tingling in legs or Weakness in arms or hands	Instability a) hands		Yes	No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or Numbness or tingling in legs or Weakness in arms or hands Weakness in legs or feet	Instability a) hands		Yes	No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or Numbness or tingling in legs or Weakness in arms or hands Weakness in legs or feet Recent change in coordination	instability  a)  hands feet		Yes	No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or Numbness or tingling in legs or Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk	instability  a)  hands feet		Yes	No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or Numbness or tingling in legs or Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk Spina biffda	instability  a)  hands feet		Yes	No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or Numbness or tingling in legs or Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk	instability  a)  hands feet		Yes	No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or Numbness or tingling in legs or Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk Spina biffda	instability  a)  hands feet		Yes	No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or Numbness or tingling in legs or Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk Spina bifida Latex allergy	instability  a)  hands feet		Yes	No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or Numbness or tingling in legs or Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk Spina bifida Latex allergy	instability  a)  hands feet		Yes	No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or Numbness or tingling in legs or Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk Spina bifida Latex allergy	instability  a)  hands feet		Yes	No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or Numbness or tingling in legs or Weakness in arms or hands Weakness in legs or feet Recent change in coordination Recent change in ability to walk Spina bifida Latex allergy	instability  a)  hands feet		Yes	No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or Numbness or tingling in legs or 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	Instability a) hands feet			No
Attantoaxial instability X-ray evaluation for attantoaxial Dislocated joints (more than one Easy bleeding Enlarged spieen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder Numbness or tingling in arms or Numbness or tingling in legs or 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	Instability a) hands feet	s to the above questions are complete ar	and correct.	ato

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

Date of birth

## PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name

PHYSICIAN REMINDERS  1. Consider additional questions on more sensitive issues  Do you feel stressed out or under a lot of pressure?  Do you feel safe, hopeless, depressed, or anxious?  Do you feel safe at your home or residence?  Have you ever tried cigarattes, 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 you Do you wear a seat belt, use a helmet, and use condoms?  2. Consider reviewing questions on cardiovascular symptoms (questions 5-14).	ir performance?	
EXAMINATION		
Height Weight □ Mal		
	n R 20/	L 20/ Corrected 🗆 Y 🗆 N
MEDICAL Appearance	HORMAL	ABNORMAL FINDINGS
<ul> <li>Marfan stigmata (kyphoscollosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li> </ul>		
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 (males only)*		
Skin		
HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic*		
MUSCULOSKELETAL	1 24 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Neck		
Back		
Shoulder/arm Elbow/forearm		
Wrist/hand/fingers	1	
Hip/thigh	<del> </del>	
Knee		
Leg/ankle		
Foot/toes		
Functional		F E
Duck-walk, single leg hop		
*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. *Consider GJ 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 of the commendation of	ment for	
Not cleared     Regulars by these combinations		
Pending further evaluation		
CI For any sports		
☐ For certain sports		
Reason		
Recommendations		
I have examined the above-named student and completed the preparticipation physical e participate in the sport(s) as outlined above. A copy of the physical exam is on record in marise after the athlete has been cleared for participation, a physician may rescind the cleare to the athlete (and parents/guardians).	y office and can be ma ance until the problem i	de available to the school at the request of the parents. If conditions is resolved and the potential consequences are completely explained
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 S	ex LI M LI F Age Date of birth
☐ Cleared for all sports without restriction	
$\hfill \Box$ Cleared for all sports without restriction with recommendations for further evaluations	ation or treatment for
□ Not cleared	
☐ Pending further evaluation	
☐ For any sports	
☐ For certain sports	
Reason	
Recommendations	ALCO STATE OF THE
	1
PHEDOCALOV INCODERSION	
EMERGENCY INFORMATION  Allowing	
Allergies	
<del></del>	
Other information	
Non occupe examp	COLOGI PINCIGIALI.
HCP DFFICE STAMP	SCHOOL PHYSICIAN:
	Reviewed on(Date)
	Approved Not Approved
	Signature
	Signature:
and can be made available to the school at the request of the parents.	icipation physical evaluation. The athlete does not present apparent contined above. A copy of the physical exam is on record in my office. If conditions arise after the athlete has been cleared for participation,
clinical contraindications to practice and participate in the sport(s) as and can be made available to the school at the request of the parents the physician may rescind the clearance until the problem is resolved (and parents/guardians).	icipation physical evaluation. The athlete does not present apparent cuttined above. A copy of the physical exam is on record in my office. If conditions arise after the athlete has been cleared for participation, and the potential consequences are completely explained to the athlet
clinical contraindications to practice and participate in the sport(s) as and can be made available to the school at the request of the parents, the physician may rescind the clearance until the problem is resolved (and parents/guardians).  Name of physician, advanced practice nurse (APN), physician assistant (PA)	icipation physical evaluation. The athlete does not present apparent contined above. A copy of the physical exam is on record in my office. If conditions arise after the athlete has been cleared for participation, and the potential consequences are completely explained to the athlet
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