

HOLLAND TOWNSHIP SCHOOL DISTRICT

710 Milford-Warren Glen Road

Milford, NJ 08848

Mr. Emil J. Suarez, Superintendent

Mrs. Nancy Yard, Principal

PERMISSION FORM

I give _____ permission to participate on a sport(s) team at the
(Student's name)
Holland Township School. Please circle each sport your child is planning to participate in
during this school year: Soccer Volleyball Boy's Basketball Girl's Basketball
Softball Baseball Gymnastics Track

I agree under all circumstances that my child use the transportation provided by the school to and from "away" games unless a written parental/guardian note states otherwise.

Realizing that such activity involves the potential for injury, which is inherent in all sports, I/we acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of rules, injuries are still a possibility. On rare occasions, these injuries can be so severe as to the result in total disability, paralysis or even death. I/we acknowledge that I/we have read and understand this warning. I give my permission for emergency treatment for injuries sustained in any athletic contest, by an emergency squad at the place of injury or at the emergency ward by the attending physician, until I/we can be notified.

I have read all the information included in this packet and have filled out all the necessary forms. PLEASE sign below and return this portion with all the necessary forms to the nurse.

Thank you.

Signature of Parent/Guardian

Date

EMERGENCY CONTACTS

Name: _____

Sport: _____

List contact numbers in the event it is necessary to reach student's parent/guardian during practice or a game.

First Contact:

Name: _____

Phone #: _____

Cell #: _____

Relationship: _____

Second Contact:

Name: _____

Phone #: _____

Cell#: _____

Relationship: _____

List any medical condition that the student's coach should be aware of: allergies, need for inhaler, etc.

Name of Insurance Carrier: _____ Policy #: _____

Physician: _____ Phone #: _____

PARENT SIGNATURE: _____ DATE: _____

**New Jersey Department of Education
ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM**

Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the parent and student and reviewed by examining provider
Part B: PHYSICAL EVALUATION FORM-Completed by examining licensed provider with MD, DO, APN or PA

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____ Date of Last Sports Physical: _____

Student's Name: _____ Sex: M F (circle one) Age: _____ Grade: _____
 Date of Birth: ____/____/____ School: _____ District: _____
 Sport(s): _____ Home Phone: (____) _____
 Provider Name (Medical Home): _____ Phone: _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name of parent/guardian: _____ Relationship to student: _____
 Phone (work): _____ Phone (home): _____ Phone (cell): _____
 Additional emergency contact: _____ Relationship to student: _____
 Phone (work): _____ Phone (home): _____ Phone (cell): _____

Directions: Please answer the following questions about the student's medical history by CIRCLING the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. **Have you ever had, or do you currently have:**
- a. Restriction from sports for a health related problem? Y / N / Don't Know
 - b. An injury or illness since your last exam? Y / N / Don't Know
 - c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know
 - (1.) An inhaler or other prescription medicine to control asthma? Y / N / Don't Know
 - d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know
 - e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
 - f. Any allergies to medications? Y / N / Don't Know
 - g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't Know
 - (1.) If yes, check type of reaction:
 Rash Hives Breathing or other anaphylactic reaction
 - (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) Y / N / Don't Know
 - h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know
 - i. A blood relative who died before age 50? Y / N / Don't Know

Explain all "yes" answers here (Include relevant dates):

List all medications here:

Medication Name	Dosage	Frequency

2. Have you ever had, or do you currently have, any of the following *head-related* conditions:
- | | |
|---|--------------------|
| a. Concussion or head injury (including "bell rung" or a "ding")? | Y / N / Don't Know |
| b. Memory loss? | Y / N / Don't Know |
| c. Knocked out? | Y / N / Don't Know |
| d. A seizure? | Y / N / Don't Know |
| e. Frequent or severe headaches (With or without exercise)? | Y / N / Don't Know |
| f. Fuzzy or blurry vision | Y / N / Don't Know |
| f. Sensitivity to light/noise | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

3. Have you ever had, or do you currently have, any of the following *heart-related* conditions:
- | | |
|--|--------------------|
| a. Restriction from sports for heart problems? | Y / N / Don't Know |
| b. Chest pain or discomfort? | Y / N / Don't Know |
| c. Heart murmur? | Y / N / Don't Know |
| d. High blood pressure? | Y / N / Don't Know |
| e. Elevated cholesterol level? | Y / N / Don't Know |
| f. Heart infection? | Y / N / Don't Know |
| g. Dizziness or passing out during or after exercise without known cause? | Y / N / Don't Know |
| h. Has a provider ever ordered a heart test (EKG, echocardiogram, stress test, Holter monitor)? | Y / N / Don't Know |
| i. Racing or skipped heartbeats? | Y / N / Don't Know |
| j. Unexplained difficulty breathing or fatigue during exercise? | Y / N / Don't Know |
| k. Any family member (blood relative): | |
| (1.) Under age 50 with a heart condition? | Y / N / Don't Know |
| (2.) With Marfan Syndrome? | Y / N / Don't Know |
| (3.) Died of a heart problem before age 50? If yes, at what age? _____ | Y / N / Don't Know |
| (4.) Died with no known reason? | Y / N / Don't Know |
| (5.) Died while exercising? If yes, was it during or after? (Circle one.) | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

4. Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat* conditions:
- | | |
|---|--------------------|
| a. Vision problems? | Y / N / Don't Know |
| (1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.) | Y / N / Don't Know |
| b. Hearing loss or problems? | Y / N / Don't Know |
| (1.) Wear hearing aides or implants? | Y / N / Don't Know |
| c. Nasal fractures or frequent nose bleeds? | Y / N / Don't Know |
| d. Wear braces, retainer or protective mouth gear? | Y / N / Don't Know |
| e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

5. Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic* conditions:
- | | |
|---|--------------------|
| a. Numbness, a "burner", "stinger" or pinched nerve? | Y / N / Don't Know |
| b. A sprain? | Y / N / Don't Know |
| c. A strain? | Y / N / Don't Know |
| d. Swelling or pain in muscles, tendons, bones or joints? | Y / N / Don't Know |
| e. Dislocated joint(s)? | Y / N / Don't Know |
| f. Upper or lower back pain? | Y / N / Don't Know |
| g. Fracture(s), stress fracture(s), or broken bone(s)? | Y / N / Don't Know |
| h. Do you wear any protective braces or equipment? | Y / N / Don't Know |

Explain all (yes) answers here (include relevant dates):

6. Have you ever had or do you currently have any of the following *general or exercise related conditions*:
- | | |
|---|--------------------|
| a. Difficulty breathing? | |
| (1.) During exercise? | Y / N / Don't Know |
| (2.) After running one mile? | Y / N / Don't Know |
| (3.) Coughing, wheezing or shortness of breath in weather changes? | Y / N / Don't Know |
| (4.) Exercise-induced asthma? | Y / N / Don't Know |
| i. Controlled with medication? (specify _____) | Y / N / Don't Know |
| ii. Experience dizziness, passing out or fainting? | Y / N / Don't Know |
| b. Viral infections (e.g. mono, hepatitis, coxsackie virus)? | Y / N / Don't Know |
| c. Become tired more quickly than others? | Y / N / Don't Know |
| d. Any of the following skin conditions: | |
| (1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts? | Y / N / Don't Know |
| (2.) Sun sensitivity? | Y / N / Don't Know |
| e. Weight gain/loss (of 10 pounds or more)? | Y / N / Don't Know |
| (1.) Do you want to weigh more or less than you do now? | Y / N / Don't Know |
| f. Ever had feelings of depression? | Y / N / Don't Know |
| g. Heat-related problems (dehydration, dizziness, fatigue, headache)? | Y / N / Don't Know |
| (1.) Heat exhaustion (cool, clammy, damp skin)? | Y / N / Don't Know |
| (2.) Heat stroke (hot, red, dry skin)? | Y / N / Don't Know |
| (3.) Muscle cramps? | Y / N / Don't Know |
| h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

7. **Females only:**
 Age of onset of menstruation: _____ How many menstrual periods in the last twelve (12) months? _____
 How many periods missed in the last twelve (12) months? _____
8. **Males only:**
 Have you had any swelling or pain in your testicles or groin? Y / N / Don't Know

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

 Signature, Parent/Guardian or Student Age 18

 Date of Signature:

THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.

ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

Part B: Physical Evaluation Form
(Completed by the examining licensed provider MD, DO, APN or PA)

-STUDENT INFORMATION-

Student's Name: _____ Sport(s): _____
 Sex: M F (circle one) Age: _____ Grade: _____ Date of Birth: _____
 Address: _____
 City/State/Zip: _____ Home Phone: _____
 School: _____ District: _____
 Parent/Guardian's Full Name: _____

- EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

If conducted by school physician check here

Name: _____ Phone: _____ Fax: _____
 Address: _____ City/State/Zip: _____

- FINDINGS OF PHYSICAL EVALUATION -

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____ bpm.
 Vision: R 20/____ L 20/____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it: Louder Softer No Change Squatting makes it: Louder Softer No Change Valsalva makes it: Louder Softer No Change
Femoral Pulses	YES	
Lungs: Auscultation/Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Assessment of physical maturation or Tanner Scale	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	
Hernia	ABSENT	
Evidence of Marfan Syndrome	ABSENT	

Most recent immunizations and dates administered:

Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Additional observations:

General Diagnosis:

General Recommendations:

THE HISTORY PREPARED BY THE PARENT/STUDENT MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE PHYSICAL EXAMINATION.

HISTORY REVIEWED AND STUDENT EXAMINED BY: Physician's/Provider's Stamp:

- Primary Care Provider
- School Physician Provider
- License Type:
 - MD/DO
 - APN
 - PA

PHYSICIAN'S/PROVIDER'S SIGNATURE: _____

Today's Date: _____

Date of Exam: _____

RESERVED FOR SCHOOL DISTRICT USE

NOTE: N.J.A.C. 6A:16-2.2 requires the school physician to provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this physical evaluation. This evaluation and the notification letter become part of the student's school health record.

History and Physical Reviewed By: _____ Date: _____

Title of Reviewer (please check one): School Nurse School Physician

Medical Eligibility Notification Sent to Parent/Guardian by School Physician _____
Date

Letter of notification is attached.

OR

Parent notification indicates that:

- Participation Approved without limitations.
- Participation Approved with limitations pending evaluation.
- Participation NOT Approved

Reason(s) for Disapproval: _____
