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 __________________________
Date of birth __________________________

Sex __________________________ Age __________ Gender ________
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

1. Has a doctor ever denied or restricted your participation in sports for any reason?
   ☐ Yes  ☐ No

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?
   ☐ Yes  ☐ No

4. Have you ever had surgery?
   ☐ Yes  ☐ No

HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever passed out or nearly passed out DURING or AFTER exercise?
   ☐ Yes  ☐ No

6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
   ☐ Yes  ☐ No

7. Does your heart ever race or skip beats (irregular beats) during exercise?
   ☐ Yes  ☐ No

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. Have you ever had a heart infection (e.g., strep throat, syphilis)?
   ☐ Yes  ☐ No

10. Do you get more tired or short of breath more quickly than your friends during exercise?
    ☐ Yes  ☐ No

11. Have you ever had an unexplained seizure?
    ☐ Yes  ☐ No

12. Do you get lightheaded or feel more short of breath than expected during exercise?
    ☐ 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)?
    ☐ Yes  ☐ No

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, catecholaminergic polymorphic ventricular tachycardia?
    ☐ Yes  ☐ No

15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?
    ☐ Yes  ☐ No

16. Has anyone in your family had unexplained fainting, explained seizures, or near drowning?
    ☐ Yes  ☐ No

BONE AND JOINT QUESTIONS

17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?
    ☐ Yes  ☐ No

18. Have you ever had any broken or fractured bones or dislocated joints?
    ☐ Yes  ☐ No

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?
    ☐ Yes  ☐ No

20. Have you ever had a stress fracture?
    ☐ Yes  ☐ No

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)
    ☐ Yes  ☐ No

22. Do you regularly use a brace, orthotics, or other assistive device?
    ☐ Yes  ☐ No

23. Do you have a bone, muscle, or joint injury that bothers you?
    ☐ Yes  ☐ No

24. Do any of your joints become painful, swollen, feel warm, or look red?
    ☐ Yes  ☐ No

25. Do you have any history of juvenile arthritis or connective tissue disease?
    ☐ Yes  ☐ No

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 __________________________


HE503
New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

S-2001/0410
# 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**

<table>
<thead>
<tr>
<th>6. Do you regularly use a brace, assistive device, or prosthetic?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Do you use any special brace or assistive device for sports?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8. Do you have any rashes, pressure sores, or any other skin problems?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>10. Do you have a visual impairment?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>11. Do you use any special devices for bowel or bladder function?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>13. Have you had autonomic dysreflexia?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>15. Do you have muscle spasticity?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Explain “yes” answers here**

---

**Please indicate if you have ever had any of the following.**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Easy bleeding</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Enlarged spleen</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Osteopenia or osteoporosis</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Weakness in arms or hands</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Spina bifida</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Latex allergy</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**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 _____________________**
Preparticipation Physical Evaluation

PHYSICIANS 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).

EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>Pulse</td>
<td>Vision R 20'</td>
<td>L 20'</td>
</tr>
</tbody>
</table>

MEDICAL

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
</tr>
</tbody>
</table>
- Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlexia, myopia, MVP, aortic insufficiency)
- Eyes, ears, nose, throat
  - Pupils equal
  - Hearing
- Neck |
- 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

| Neck |
| Back |
| Shoulder/arm |
| Elbow/forearm |
| Wrist/hand/fingers |
| Hip/thigh |
| Knee |
| Leg/ankle |
| Foot/toes |
- Functional
  - Duck-walk, single leg hop

☐ 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 __________________________
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 ______________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

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 __________________________

Completed Cardiac Assessment Professional Development Module
Date ___________ Signature __________________________
<table>
<thead>
<tr>
<th>Disease(s)</th>
<th>Meets Immunization Requirements</th>
<th>Comments</th>
</tr>
</thead>
</table>
| DTaP//DTP                  | **Age 1-6 years:** 4 doses, with one dose given on or after the 4th birthday, OR any 5 doses.  
**Age 7-9 years:** 3 doses of Td or any previously administered combination of DTP, DTaP, and DT to equal 3 doses | Any child entering pre-school, and/or pre-Kindergarten needs a minimum of 4 doses. A booster dose is needed on or after the fourth birthday, to be in compliance with Kindergarten attendance requirements. Pupils after the seventh birthday should receive adult type Td. Please note: there is no acceptable titer test for pertussis. |
| Tdap                      | **Grade 6** (or comparable age level for special education programs): 1 dose                   | For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. A child is not required to have a Tdap dose until FIVE years after the last DTP/DTaP or Td dose.                                           |
| Polio                     | **Age 1-6 years:** 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses.  
**Age 7 or Older:** Any 3 doses                                                   | Any child entering pre-school, and/or pre-Kindergarten needs a minimum of 3 doses. A booster dose is needed on or after the fourth birthday to be in compliance with Kindergarten attendance requirements. Either Inactivated polio vaccine (IPV) or oral polio vaccine (OPV) separately or in combination is acceptable. Polio vaccine is not required of pupils 18 years or older.* |
| Polio                     | If born before 1-1-90, 1 dose of a live measles-containing vaccine on or after the first birthday.  
If born on or after 1-1-90, 2 doses of a live measles-containing vaccine on or after the first birthday. | Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs a minimum of 1 dose of measles vaccine. Any child entering Kindergarten needs 2 doses. Intervals between first and second measles-containing vaccine doses cannot be less than 1 month. Laboratory evidence of immunity is acceptable.** |
| Measles                   | 1 dose of live mumps-containing vaccine on or after the first birthday.  
1 dose of live rubella-containing vaccine on or after the first birthday              | Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs 1 dose of rubella and mumps vaccine. Any child entering Kindergarten needs 1 dose each. Laboratory evidence of immunity is acceptable.** |
| Rubella and Mumps         | 1 dose on or after the first birthday                                                          | All children 19 months of age and older enrolled into a child care/pre-school center after 9-1-04 or children born on or after 1-1-98 entering the school for the first time in Kindergarten or Grade 1 need 1 dose of varicella vaccine. Laboratory evidence of immunity, physician’s statement or a parental statement of previous varicella disease is acceptable. |
| Varicella                 | 1 dose on or after the first birthday                                                          | Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of Hib-containing vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of Hib-containing vaccine is needed after the first birthday. *** |
| Haemophilus influenziae B (Hib) | **Age 2-11 Months:** 2 doses  
**Age 12-59 Months:** 1 dose                                                                 | Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of Hib-containing vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of Hib-containing vaccine is needed after the first birthday. *** |
| Hepatitis B               | **K-Grade 12:** 3 doses or  
**Age 11-15 years:** 2 doses                                                                 | If a child is between 11-15 years of age and has not received 3 prior doses of Hepatitis B then the child is eligible to receive 2-dose Hepatitis B Adolescent formulation. |
| Pneumococcal             | **Age 2-11 months:** 2 doses  
**Age 12-59 months:** 1 dose                                                                 | Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of pneumococcal conjugate vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of pneumococcal conjugate vaccine is needed after the first birthday. *** |
| Meningococcal            | Entering Grade 6 (or comparable age level for Special Ed programs): 1 dose                     | For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. This applies to students when they turn 11 years of age and attending Grade 6.*** |
| Influenza                 | **Ages 6-59 Months:** 1 dose annually                                                           | For children enrolled in child care, pre-school, or pre-Kindergarten on or after 9-1-08. 1 dose to be given between September 1 and December 31 of each year. Students entering school after December 31 up until March 31 must receive 1 dose since it is still flu season during this time period. |
New Jersey Department of Health

MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL

* Footnote: The requirement to receive a school entry booster dose of DTP or DTaP after the child’s 4th birthday shall not apply to children while in child care centers, preschool or pre-kindergarten classes or programs.

The requirement to receive a school entry dose of OPV or IPV after the child’s 4th birthday shall not apply to children while in child care centers, preschool or pre-kindergarten classes or programs.

** Footnote: Antibody Titer Law (Holly’s Law)—This law specifies that a titer test demonstrating immunity be accepted in lieu of receiving the second dose of measles-containing vaccine. The tests used to document immunity must be approved by the U.S. Food and Drug Administration (FDA) for this purpose and performed by a laboratory that is CLIA certified.

*** Footnote: No acceptable immunity tests currently exist for Haemophilus Influenzae type B, Pneumococcal, and Meningococcal.

Please Note The Following:

The specific vaccines and the number of doses required are intended to establish the minimum vaccine requirements for child-care center, preschool, or school entry and attendance in New Jersey. These intervals are not based on the allotted time to receive vaccinations. The intervals indicate the vaccine doses needed at earliest age at school entry. Additional vaccines, vaccine doses, and proper spacing between vaccine doses are recommended by the Department in accordance with the guidelines of the American Academy of Pediatrics (AAP) and Advisory Committee on Immunization Practices (ACIP), as periodically revised, for optimal protection and additional vaccines or vaccine doses may be administered, although they are not required for school attendance unless otherwise specified.

Serologic evidence of immunity (titer testing) is only accepted as proof of immunity when no vaccination documentation can be provided or prior history is questionable. It cannot be used in lieu of receiving the full recommended vaccinations.

Provisional Admission:
Provisional admission allows a child to enter/attend school after having received a minimum of one dose of each of the required vaccines. Pupils must be actively in the process of completing the series. Pupils <5 years of age, must receive the required vaccines within 17 months in accordance with the ACIP recommended minimum vaccination interval schedule. Pupils 5 years of age and older, must receive the required vaccines within 12 months in accordance with the ACIP recommended minimum vaccination interval schedule.

Grace Periods:
- 4-day grace period: All vaccine doses administered less than or equal to four days before either the specified minimum age or dose spacing interval shall be counted as valid and shall not require revaccination in order to enter or remain in a school, pre-school, or child care facility.
- 30-day grace period: Those children transferring into a New Jersey school, pre-school, or child care center from out of state/out of country may be allowed a 30-day grace period in order to obtain past immunization documentation before provisional status shall begin.