School Health Services Requirements

It is the practice of the Princeton Public Schools to require a physical examination from all students new to the district (including those starting Pre-K or Kindergarten for the first time), and all students in 3rd, 6th, 9th, and 11th grades. A report from your private physician regarding a recent (within the last 6 months) examination can be accepted in lieu of a new examination.

We recommend, and many parents prefer, that these required examinations be conducted by the family’s physician because he/she is more familiar with the student’s health history and a private office exam is more comprehensive. However, if your child does not have a physician, you may request an examination be conducted by the school physician.

High school and middle school students participating in interscholastic sports must have a physical examination prior to the first practice session.

Chapter 14 of the New Jersey State Sanitary Code requires that all school children have certain immunizations. The Code calls for the exclusion of children who do not have the mandated immunizations. The following summarizes the required immunizations:

Mantoux Tuberculin Skin Test
Students in any grade who have transferred from a country with a high incidence of tuberculosis will be tested with the Mantoux Tuberculin Skin Test. This test will be considered valid if administered within the previous 6 months for those who are required to be tested.

Required Immunizations for New Jersey Schools for Children Pre-Kindergarten
4 doses DTP or D/Tap, 3 doses of Polio vaccine, 1 dose MMR, 1 dose HiB, 1 dose Varicella or history of disease; 3 doses of Hepatitis B are recommended but not required until Kindergarten; Pneumococcal Conjugate vaccine**, Influenza vaccine**

*Beginning September 1, 2008, every child 12-months through 59-months of age attending preschool shall have received 1 dose of Pneumococcal Conjugate vaccine on or after their 1st birthday.

**Beginning September 1, 2008, children 6-months through 59-months of age attending preschool shall annually receive at least 1 dose of Influenza vaccine between September 1 and December 31 of each year.

Required Immunizations for New Jersey Schools for Children Kindergarten or Grade 1
3 doses Hepatitis B, 4 doses DTP/DTap, 3 doses Polio vaccine, 2 doses MMR; 1 dose Varicella vaccine or history of disease.

Required Immunization for New Jersey Schools for Children Age 7 of Older
3 doses Td, 3 doses Polio vaccine, 2 doses MMR, 2 or 3 doses of Hep B

Recent Changes in Immunization Mandates for Grade 6
TDaP Vaccine (Tetanus, diphtheria, acellular pertussis)
Beginning September 1, 2008, every child born on or after January 1, 1997, and entering or transferring into or attending Grade 6 shall have received 1 dose of a meningococcal-containing vaccine, such as the medically preferred meningococcal conjugate vaccine (applies to students when they turn 11-years of age and attend Grade 6).

If you have any questions, consult the school nurse.
The code also requires that proof of prior immunizations can only be accepted in the form of an official school health record, a Public Health Department certificate, or a form signed and stamped by a medical physician or certified osteopath. The proof must be documented with month, day, and year of administration.

We ask that parents either bring to school an English translation of their child’s medical record or bring someone to translate the record when they register their child.

The attached form should be returned to the school nurse where the student will be attending school. The forms regarding students who will be entering Kindergarten or Grades 3, 6, 9, or 11 as of next fall should be returned by September. New entrants to other grades should bring immunization records when registering, or on their first day of school.
Athletic Activities Information

Participation in interscholastic athletics and related co-curricular programs contributes to health, physical skills, instructional maturity, social competencies, and moral values of our students. Athletics extend the educational experience while developing responsibility and cooperation. Consequently, we encourage students to participate during three seasons of a wide variety of individual and team sports.

Any student planning to participate in a sport must fulfill the following requirements:

1. Academic eligibility:
   a. 9th grade – No academic requirements for Fall or Winter participation. For Spring sports, a 9th grader must have earned 15.00 credits at the end of the first semester in January.
   b. 10th, 11th, and 12th grades – Require 30.00 credits earned on the previous June report card for Fall and Winter sports and 15.00 at the end of the first semester for participation in a Spring sport.

2. Parent Permission – “Student Athletic Information” form must be completed and signed by parent/guardian. Forms can be picked-up in the Nurse’s Office, the Main Office, or the Athletic Office. A new form is required for each season and CANNOT be submitted until 2 months prior to the start of any season. All sections of the form must be completed – these forms are for emergency treatment!

3. Physical Examination and Updated Health History – A current Physical must be on file in the Health Office. A physical is good for 365 days from the date of exam and is to be provided by the Athlete’s personal physician. An updated Health History must be submitted for each season and submitted with the Athletic Information form for that season.

4. A student is ineligible if he/she reaches the age of 19 prior to September 1 during 9th through 12th grade.

5. There are some residency rules from 10th through 12th grade for transfer students (check with the Athletic Office if you are transferring into PHS).

PHS sports include the following:

   FALL: Cheerleading (co-ed, not an NJSIAA sport), Boys and Girls Cross Country, Field Hockey, Football, Boys and Girls Soccer, and Girls Tennis. Practice starts on or around August 15. Confirm start dates and times with the Athletic Office after June 15.

   WINTER: Practice starts November 15 for Boys and Girls Ice Hockey (Girls Ice Hockey is not an NJSIAA sport) and Boys and Girls Swimming. Practice starts November 26 for Boys and Girls Basketball, Boys and Girls Winter Track, Wrestling, and Fencing.

   SPRING: Practice begins March 4 for Baseball, Boys and Girls Golf, Boys and Girls Lacrosse, Softball, Boys and Girls Outdoor Track, and Boys Tennis.

If you have any questions, please call the Athletic Director, John Miranda, at 609.806.4290 X1 or the Athletic Secretary, Kathy Herzog, at 609.806.4290 X2.

Forms CANNOT be submitted more than TWO MONTHS before start date for each season!
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: __________________________

<table>
<thead>
<tr>
<th>Student’s Name: __________________________</th>
<th>Sex: M  F (circle one)</th>
<th>Age: _______  Grade: _______</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth: <strong>/</strong>/______</td>
<td>School: __________________________</td>
<td>District: __________________________</td>
</tr>
<tr>
<td>Sport(s): __________________________</td>
<td>Home Phone: (____) _______</td>
<td></td>
</tr>
<tr>
<td>Provider Name (Medical Home): __________________________</td>
<td>Phone: __________________________</td>
<td>Fax: __________________________</td>
</tr>
</tbody>
</table>

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/EpInen 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:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Part A Page 1 of 3  
NJDOE/APPEF Revised 3/10  
Use of this form is required by N.J.A.C. 6A:16—Programs to Support Student Development
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. Frequent or severe headaches (With or without exercise)? Y / N / Don’t Know
   e. 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):

Part A Page 2 of 3
NJDOE/APPEF Revised 3/10
Use of this form is required by N.J.A.C. 6A:16-Programs to Support Student Development
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?
         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)?
      (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

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

Part B Page 1 of 4

NJOE/APPF Revised 3/10 Use of this form is required by N.J.A.C. 6A:16-Programs to Support Student Development
Most recent immunizations and dates administered:

Medications currently prescribed, with dose and frequency:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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.
CLEARANCES: This section is completed by the examining healthcare provider.

After examining the student and reviewing the medical history the student is:

☐ A. **Cleared** for participation in **all** sports without restrictions.

☐ B. **Not cleared** for participation in **any** sport until evaluation/treatment of:

☐ C. **Cleared for limited participation** in the following types of sports only. Please see below for sport classifications. **CHECK ALL THAT APPLY**

- [ ] CONTACT/COLLISION
- [ ] LIMITED CONTACT
- [ ] NON-CONTACT/STRENUOUS
- [ ] NON-CONTACT/NON-STRENUOUS

Limitations due to: ________________________________

NOTES TO THE EXAMINING PROVIDER

Conditions requiring clearance before sports participation include, but are not limited to the following:

- Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; Seizure Disorder; Marfan’s Syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

<table>
<thead>
<tr>
<th>Contact/Collision</th>
<th>Limited Contact</th>
<th>Strenuous</th>
<th>Non-Contact</th>
<th>Non-strenuous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basketball</td>
<td>Baseball</td>
<td>Discus</td>
<td>Bowling</td>
<td></td>
</tr>
<tr>
<td>Diving</td>
<td>Cheerleading</td>
<td>Javelin</td>
<td></td>
<td>Golf</td>
</tr>
<tr>
<td>Field Hockey</td>
<td>Fencing</td>
<td>Shot put</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Football</td>
<td>High Jump</td>
<td>Rowing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ice Hockey</td>
<td>Pole vault</td>
<td>Running/Cross Country</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lacrosse</td>
<td>Gymnastics</td>
<td>Strength Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soccer</td>
<td>Skiing</td>
<td>Swimming</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrestling</td>
<td>Softball</td>
<td>Tennis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Volleyball</td>
<td>Track</td>
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<td></td>
</tr>
</tbody>
</table>

Effects of physiologic maneuvers on heart sounds

<table>
<thead>
<tr>
<th>Position</th>
<th>murmurs/valves/other changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standing</td>
<td>Increases murmur of HCM</td>
</tr>
<tr>
<td></td>
<td>Decreases murmur of AS, MR</td>
</tr>
<tr>
<td></td>
<td>MVP click occurs earlier in systole</td>
</tr>
<tr>
<td>Squatting</td>
<td>Increases murmur of AS, MR, AI</td>
</tr>
<tr>
<td></td>
<td>Decreases murmur of MCH</td>
</tr>
<tr>
<td></td>
<td>MVP click delayed</td>
</tr>
<tr>
<td>Valsalva</td>
<td>Increases murmur of HCM</td>
</tr>
<tr>
<td></td>
<td>Decreases murmur of AS, MR</td>
</tr>
<tr>
<td></td>
<td>MVP click occurs earlier in systole</td>
</tr>
</tbody>
</table>

Physical Stigmata of Marfan’s Syndrome

- Kyphosis
- High arched palate
- Pectus excavatum
- Arachnodactyly
- Arm span > height 1.05:1 or greater
- Mitral Valve Prolapse
- Aortic Insufficiency
- Myopia
- Lenticular dislocation

HCM: Hypertrophic Cardiac Myopathy
AS: Aortic Stenosis
AI: Aortic Insufficiency
MR: Mitral Regurgitation
MVP: Mitral Valve Prolapse

Part B Page 3 of 4

NJDOE/APPEF Revised 3/10

Use of this form is required by N.J.A.C. 6A:16-Programs to Support Student Development
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: ___________________________________________  

_________________________________________________________________