To: Parents/Guardians

Re: School Health Services Requirements

It is the practice of the Princeton Public Schools to require a physical examination of all students new to the district (including those starting Pre-K or Kindergarten for the first time), and all students in the third, sixth, ninth and eleventh grades. A report from your private physician regarding a recent (within the last year) 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 six months for those who are required to be tested.

**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 4 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, preschool or child care facility.

- **30-Day Grace Period** – Those children transferring into a New Jersey school, preschool, 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 documentations before provisional status shall begin.
<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.* |
| Measles               | 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.** |
| Rubella and Mumps     | 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. ** |
| Varicella             | 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. |
| Haemophilus influenzae 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 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 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: (______) __________ Fax: ___________________________

Provider Name (Medical Home): ___________________________ Phone: ___________________________

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:

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Frequency</th>
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</thead>
<tbody>
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</tbody>
</table>
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):
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?
      (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)?  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 -

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>Standing makes it: Louder Softer No Change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Squatting makes it: Louder Softer No Change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Valsalva makes it: Louder 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

NJDDE/PEPE 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>
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</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**

<table>
<thead>
<tr>
<th>CONTACT/COLLISION</th>
<th>NON-CONTACT/STRENUOUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIMITED CONTACT</td>
<td>NON-CONTACT/NON-STRENUOUS</td>
</tr>
</tbody>
</table>

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>SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact/Collision</td>
</tr>
<tr>
<td>Basketball</td>
</tr>
<tr>
<td>Diving</td>
</tr>
<tr>
<td>Field Hockey</td>
</tr>
<tr>
<td>Football</td>
</tr>
<tr>
<td>Ice Hockey</td>
</tr>
<tr>
<td>Lacrosse</td>
</tr>
<tr>
<td>Soccer</td>
</tr>
<tr>
<td>Wrestling</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Effects of physiologic maneuvers on heart sounds

<table>
<thead>
<tr>
<th>Maneuver</th>
<th>Effect on Murmur</th>
<th>Physical Stigmata of Marfan’s Syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standing</td>
<td>Increases murmur of HCM</td>
<td>Kyphosis</td>
</tr>
<tr>
<td></td>
<td>Decreases murmur of AS, MR</td>
<td>High arched palate</td>
</tr>
<tr>
<td></td>
<td>MVP click occurs earlier in systole</td>
<td>Arachnodactyly</td>
</tr>
<tr>
<td>Squatting</td>
<td>Increases murmur of AS, MR, AI</td>
<td>Arm span &gt; height 1.05:1 or greater</td>
</tr>
<tr>
<td></td>
<td>Decreases murmur of MCH</td>
<td>Mitral Valve Prolapse</td>
</tr>
<tr>
<td></td>
<td>MVP click delayed</td>
<td>Aortic Insufficiency</td>
</tr>
<tr>
<td>Valsalva</td>
<td>Increases murmur of HCM</td>
<td>Myopia</td>
</tr>
<tr>
<td></td>
<td>Decreases murmur of AS, MR</td>
<td>Lenticular dislocation</td>
</tr>
<tr>
<td></td>
<td>MVP click occurs earlier in systole</td>
<td></td>
</tr>
</tbody>
</table>

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: ____________________________________________

_________________________________________________________________