

**ATTENTION PARENT/GUARDIAN:** The preparticipation 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

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

### Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ 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

### PLEASE Explain "Yes" answers below. Physicals without yes questions answered will not be approved by the school physician.

GENERAL QUESTIONS	YES	NO
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	YES	NO
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	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)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	YES	NO
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. 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?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	YES	NO
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

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  
**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		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure 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 impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

---



---



---



---



---

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

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
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 hands		
Numbness or tingling in legs or feet		
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

---



---



---



---



---

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 \_\_\_\_\_



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

## PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
Date of Exam: \_\_\_\_\_

### PHYSICIAN 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		
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP / ( / )	Pulse	Vision R 20/ L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart <sup>a</sup> • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) <sup>b</sup>		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic <sup>c</sup>		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.

<sup>c</sup>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 for \_\_\_\_\_

Not cleared

Pending further evaluation

For any sports

For certain sports \_\_\_\_\_

Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

I have examined the above-named student and completed the pre-participation 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) (print/type) \_\_\_\_\_ Date \_\_\_\_\_

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 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of Exam: \_\_\_\_\_

### HCP OFFICE STAMP

### SCHOOL PHYSICIAN:

Reviewed on \_\_\_\_\_  
 (Date)

Approved \_\_\_\_\_ Not Approved \_\_\_\_\_

Signature: \_\_\_\_\_

I have examined the above-named student and completed the pre-participation 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

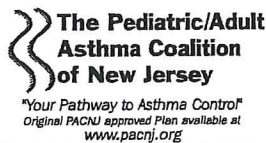
Date \_\_\_\_\_ Signature \_\_\_\_\_



# Asthma Treatment Plan

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)

**(Please Print)**



Name		Date of Birth	Effective Date
Doctor	Parent/Guardian (if applicable)		Emergency Contact
Phone	Phone		Phone

## HEALTHY



You have all of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above \_\_\_\_\_

**Take daily medicine(s). All metered dose inhalers (MDI) to be used with spacers.**

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Advair® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500	.....1 inhalation twice a day
<input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230	.....2 puffs MDI twice a day
<input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220	.....1, <input type="checkbox"/> 2 inhalations a day
<input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220	.....2 inhalations twice a day
<input type="checkbox"/> Flovent® Diskus® 50 mcg	.....1 inhalation twice a day
<input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180	.....1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Pulmicort Respules® <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0	..1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day
<input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80	.....2 inhalations twice a day
<input type="checkbox"/> Singulair <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg	.....1 tablet daily
<input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160	.....2 puffs MDI twice a day
<input type="checkbox"/> Other	
<input type="checkbox"/> None	

**Remember to rinse your mouth after taking inhaled medicine.**

If exercise triggers your asthma, take this medicine \_\_\_\_\_ minutes before exercise.

## CAUTION



You have any of these:

- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: \_\_\_\_\_

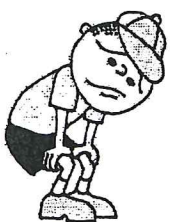
And/or Peak flow from \_\_\_\_\_ to \_\_\_\_\_

**Continue daily medicine(s) and add fast-acting medicine(s).**

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
<input type="checkbox"/> Accuneb® <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	.....1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	.....1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil®	.....2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex®	.....2 puffs MDI every 4 hours as needed
<input type="checkbox"/> Xopenex® <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	..1 unit nebulized every 4 hours as needed
<input type="checkbox"/> Increase the dose of, or add:	

➔ If fast-acting medicine is needed more than 2 times a week, except before exercise, then call your doctor.

## EMERGENCY



Your asthma is getting worse fast:

- Fast-acting medicine did not help within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue

And/or Peak flow below \_\_\_\_\_

**Take these medicines NOW and call 911. Asthma can be a life-threatening illness. Do not wait!**

<input type="checkbox"/> Accuneb® <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	.....1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg	.....1 unit nebulized every 20 minutes
<input type="checkbox"/> Albuterol <input type="checkbox"/> Pro-Air <input type="checkbox"/> Proventil®	.....2 puffs MDI every 20 minutes
<input type="checkbox"/> Ventolin® <input type="checkbox"/> Maxair <input type="checkbox"/> Xopenex®	.....2 puffs MDI every 20 minutes
<input type="checkbox"/> Xopenex® <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg	..1 unit nebulized every 20 minutes
<input type="checkbox"/> Other	

## Triggers

Check all items that trigger patient's asthma:

- Chalk dust
- Cigarette Smoke & second hand smoke
- Colds/Flu
- Dust mites, dust, stuffed animals, carpet
- Exercise
- Mold
- Ozone alert days
- Pests - rodents & cockroaches
- Pets - animal dander
- Plants, flowers, cut grass, pollen
- Strong odors, perfumes, cleaning products, scented products
- Sudden temperature change
- Wood Smoke
- Foods: \_\_\_\_\_

Other: \_\_\_\_\_

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey, and this publication are supported by a grant from the New Jersey Department of Health and Senior Services (NJHSS), with funds provided by the U.S. Centers for Disease Control and Prevention (CDC) under Cooperative Agreement 5U59EH000206-2. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NJHSS or the USDOH.

Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreements XA5294407-4 and XA7257070-1 to the American Lung Association of New Jersey, it has not gone through the Agency's publication review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred.

**EFFECTIVE MARCH 2008**  
Permission to reproduce blank form  
Approved by the New Jersey Throat & Larynx Society

### FOR MINORS ONLY:

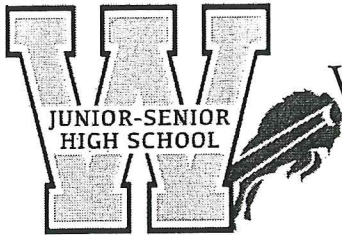
- This student is capable and has been instructed in the proper method of self-administering of the inhaled medications named above in accordance with NJ Law.
- This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

PHYSICIAN STAMP

Make a copy for patient and for physician file. For children under 18, send original to school nurse or child care provider.



# WOODBURY CITY PUBLIC SCHOOLS

*A Leader in Personalizing Education*

## WOODBURY JUNIOR-SENIOR HIGH SCHOOL MEDICATION FORM

### PARENTAL PERMISSION

Please administer the enclosed medication to my child during school hours. I understand that the medication must be in its original container. I release WJSHS from all liability that may occur as a result of the use of this medication or the self-administration of approved medications by my child. The School Nurse has my permission to contact my child's Health Care Provider if there is a question concerning this medication.

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Medication and dosage: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PHYSICIAN, DENTIST, ADVANCED PRACTICE NURSE, OR PHYSICIAN'S ASSISTANT AUTHORIZAION

Student's Name: \_\_\_\_\_

Medication and Dose: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Side Effects: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

If this medication is for a life threatening condition such as anaphylaxis, diabetes, or asthma, may the student self-administer this medication? Yes \_\_\_\_\_ No \_\_\_\_\_

The above student is under my care for the above condition. I authorize the School Nurse to administer the ordered medication as prescribed.

Health Care Provider's Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE: This form is also required for all over the counter medication. Please use a separate form for each medication needed.**