EVESHAM TOWNSHIP SCHOOL DISTRICT

INTERSCHOLASTIC SPORTS - PERMISSION TO PARTICIPATE

			Grade	House
Name of Student			Date of B	irth
I give permissio sports programs	•	participate in the into	erscholasti	c and/or intramural
responsibility for my regulations in the into	child's safety. I understa erest of safety and good s	I hazards involved in this and that my child is expect sportsmanship. Consequen include suspension or exp	ed to obey the ces of failure	coach's rules and to abide by the rules, or to
Parent/Guardian	Signature			Date
• Forms must b	of Education Athletic phe completed in their entire	nysical form is the only for rety. Any incomplete form aving your doctor's office!	s will be retur	*
An inhaler <u>m</u>				n the nurse's office. n school and after the nurse
 If your child to An inhaler mileaves for the EPIPEN / AUVI-Q If your child I must be on fill An injector m 	ust be available at all time day. Please make arrang has an epinephrine injected in the nurse's office.	es, as teams practice and pements with the nurse. or for life-threatening ements, as teams practice and periods.	olay away fron	

Student Signature

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

me					Date of birth		
·	Age	Grade S	chool		Sport(s)		
edicines an	d Allergies: Pl	ease list all of the prescription and ov	er-the-co	unter m	nedicines and supplements (herbal and nutritional) that you are currently	taking	
o you have a 1 Medicines	ny allergies?	☐ Yes ☐ No If yes, please in☐ Pollens	dentify spe	ecific al	lergy below. □ Food □ Stinging Insects		
olain "Yes" a	nswers below.	Circle questions you don't know the	answers t	0.			
NERAL QUES	TIONS		Yes	No	MEDICAL QUESTIONS	Yes	ı
. Has a doctor any reason?	ever denied or r	estricted your participation in sports for			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
-		dical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?		L
below: D /	Asthma	emia 🗆 Diabetes 🗀 Infections			28. Is there anyone in your family who has asthma?		-
	er spent the nigh	t in the hospital?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
	er had surgery?				30. Do you have groin pain or a painful bulge or hernia in the groin area?		
ART HEALTH	QUESTIONS AB	OUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?		
		nearly passed out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?		L
AFTER exerc		t, pain, tightness, or pressure in your			33. Have you had a herpes or MRSA skin infection?		_
chest during		t, pain, agrialess, or pressure in your			34. Have you ever had a head injury or concussion?		╀
. Does your h	eart ever race or	skip beats (irregular beats) during exercise	?		35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
		at you have any heart problems? If so,			36. Do you have a history of seizure disorder?		T
check all tha		☐ A heart murmur			37. Do you have headaches with exercise?		
☐ High ch	olesterol	☐ A heart infection Other:			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
	ever ordered a t	est for your heart? (For example, ECG/EKG			39. Have you ever been unable to move your arms or legs after being hit or falling?		
		el more short of breath than expected			40. Have you ever become ill while exercising in the heat?		T
during exerc	ise?				41. Do you get frequent muscle cramps when exercising?		
	er had an unexpla				42. Do you or someone in your family have sickle cell trait or disease?		L
Do you get r. during exerc		t of breath more quickly than your friends			43. Have you had any problems with your eyes or vision?		╀
		OUT YOUR FAMILY	Yes	No	44. Have you had any eye injuries? 45. Do you wear glasses or contact lenses?		╀
		lative died of heart problems or had an			45. Do you wear grasses of contact tenses? 46. Do you wear protective eyewear, such as goggles or a face shield?		╁
		udden death before age 50 (including cident, or sudden infant death syndrome)?	,		47. Do you worry about your weight?		\vdash
		ave hypertrophic cardiomyopathy, Marfan			48. Are you trying to or has anyone recommended that you gain or		t
syndrome, a	rrhythmogenic rig	ht ventricular cardiomyopathy, long QT			lose weight?		L
	nort QT syndrom ventricular tachy	e, Brugada syndrome, or catecholaminergi /cardia?	C		49. Are you on a special diet or do you avoid certain types of foods?		┡
. Does anyone	in your family h	ave a heart problem, pacemaker, or			50. Have you ever had an eating disorder? 51. Do you have any concerns that you would like to discuss with a doctor?		\vdash
implanted d					FEMALES ONLY		
	in your family had near drowning?	d unexplained fainting, unexplained			52. Have you ever had a menstrual period?		
	IT QUESTIONS		Yes	No	53. How old were you when you had your first menstrual period?		
. Have you ev	er had an injury t	o a bone, muscle, ligament, or tendon actice or a game?			54. How many periods have you had in the last 12 months?		
		n or fractured bones or dislocated joints?			Explain "yes" answers here		
. Have you ev	er had an injury t	hat required x-rays, MRI, CT scan, cast, or crutches?					
	er had a stress fr						
. Have you ev	er been told that	you have or have you had an x-ray for nec ability? (Down syndrome or dwarfism)	k				
		orthotics, or other assistive device?					
	-	or joint injury that bothers you?					
		painful, swollen, feel warm, or look red?]		
. Do you have	any history of ju	venile arthritis or connective tissue disease	?]		

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9-2681/0410

■ PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam							
Name			Date of birth				
Sex Age	Grade	School					
Type of disability							
2. Date of disability							
Classification (if availa	ble)						
4. Cause of disability (bir	th, disease, accident/trauma, other)						
5. List the sports you are	interested in playing						
				Yes	No		
	brace, assistive device, or prosthetic						
	I 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?							
	r discomfort when urinating?	on?					
13. Have you had autonom							
		nermia) or cold-related (hypothermia) illnes	Con				
15. Do you have muscle sp		ierma, or colu-related (hypothermia) limes	6:				
· ·	seizures that cannot be controlled by	medication?					
Explain "yes" answers her	le .						
Please indicate if you have	e ever had any of the following.						
Atlantoaxial instability				Yes	No		
X-ray evaluation for atlanto	pavial inetability						
Dislocated joints (more tha							
Easy bleeding	0110)						
Enlarged spleen							
Hepatitis							
Osteopenia or osteoporosis	<u> </u>						
Difficulty controlling bowel							
Difficulty controlling bladde							
Numbness or tingling in an	ms or hands						
Numbness or tingling in leg	gs or feet						
Weakness in arms or hand	S						
Weakness in legs or feet							
Recent change in coordina	tion						
Recent change in ability to	walk						
Spina bifida							
Latex allergy							
Explain "yes" answers he	re						
I hereby state that, to the	best of my knowledge, my answe	s to the above questions are complete a	and correct.				
Cignoture of othloto		Signature of parent/guardian		Date			
Signature of athlete							

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice 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 **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 □ Male □ Female BP Pulse Vision R 20/ L 20/ Corrected D Y \square N MEDICAL NORMAL ABNORMAL FINDINGS · 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^a Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) Pulses · Simultaneous femoral and radial pulses Lungs Abdomen Genitourinary (males only)b . HSV, lesions suggestive of MRSA, tinea corporis Neurologic o MUSCULOSKELETAL Neck Back Shoulder/arm Elbow/forearm Wrist/hand/fingers Hip/thigh Knee Leg/ankle Foot/toes **Functional** · Duck-walk, single leg hop ^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. ^bConsider GU exam if in private setting. Having third party present is recommended.
^cConsider 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 _ 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/quardians). Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)__ Date of exam

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Phone _

Address

Signature of physician, APN, PA

■ PREPARTICIPATION PHYSICAL EVALUATION

CLEARANCE FORM

Name	Sex M M F Age Date of birth
☐ Cleared for all sports without restriction	
$\hfill\Box$ Cleared for all sports without restriction with recommendations for further evaluations	aluation or treatment for
□ Not cleared	
□ Pending further evaluation	
☐ For any sports	
☐ For certain sports	
Reason	
Recommendations	
EMERGENCY INFORMATION	
Allergies	
Other information	
Other information	
HCP OFFICE STAMP	SCHOOL PHYSICIAN:
	Reviewed on
	Reviewed on(Date)
	Approved Not Approved
	Signature:
clinical contraindications to practice and participate in the sport(s) and can be made available to the school at the request of the paren	articipation physical evaluation. The athlete does not present apparent as outlined above. A copy of the physical exam is on record in my office its. If conditions arise after the athlete has been cleared for participation, ed 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	
DateSignature	