

Washington Township High School
Department of Athletics
Student Athlete Physical Information

According to New Jersey State Code (N.J.A.C. 6A:16), students must have their sports physicals performed at their “medical home” (family physician). If you do not have a “medical home”, contact the Athletic Office to make alternative arrangements.

Please note the following information about sports physicals:

- All physicals must be completed using the forms provided by the school.
 - Part A: Health History Questionnaire, to be completed by the parent
 - Part B: Physical Evaluation Form, to be completed by the physician/health care provider). No other forms will be accepted. These forms may be downloaded from the District website at www.wtps.org (go to High School/ Athletic Department page) or picked up from the athletic office.
 - Sports physicals must have been completed within 365 days of the first day of tryouts for any given sport.
 - All physicals must be reviewed by the school physician, per regulation. Therefore they must be submitted by the deadline.
1. If you answer yes to question 1.c (1.) on the Health History Questionnaire, then your physician must complete the asthma action plan.
 2. All forms must be completed in full or they will be returned as incomplete.

NOTE *Part B, page 3 of 4 – Student’s Physician must sign and date both history review sections.*

All forms must be submitted by the following dates per sport season.

Fall	August 1st
Winter	November 1st
Spring	February 1st

DO NOT GIVE THE PHYSICAL TO YOUR SPORT COACH

Forms are to be delivered to the Athletic Office

Thank you for your cooperation. If you have any questions, please contact the Athletic Department, 856-589-8500 Ext. 7219.

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: (____) _____

Provider Name (Medical Home): _____ Phone: _____ Fax: _____

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: | |
| <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> 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:

Medication Name	Dosage	Frequency

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 |
| c. A seizure? | 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? Y / N / Don't Know
 - (4.) Exercise-induced asthma? Y / N / Don't Know
 - 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 -

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____ bpm.
 Vision: R 20/____ L 20/____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

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

Most recent immunizations and dates administered:

Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

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: (See notes at bottom for conditions requiring attention and for a list of sports by level of contact)

- A. Student is cleared for participation in **all** sports without restriction.
 - B. Student is **withheld clearance** for participation in any sport until evaluation / treatment of:

 - C. Student is cleared for participation in **limited types** of sports which **exclude** the following types of sports contact: (CHECK ALL THAT APPLY)
 CONTACT/COLLISION NON-CONTACT/STRENUOUS
 LIMITED CONTACT NON-CONTACT/NON-STRENUOUS
- Due to: _____

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: _____

HISTORY REVIEWED BY:

Name _____ Today's Date: _____
SIGNATURE: _____ Review Date: _____

RESERVED FOR SCHOOL DISTRICT USE

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 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.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Basketball	Baseball	Discus	Bowling
Diving	Cheerleading	Javelin	Golf
Field Hockey	Fencing	Shot put	
Football	High Jump	Rowing	
Ice Hockey	Pole vault	Running/Cross Country	
Lacrosse	Gymnastics	Strength Training	
Soccer	Skiing	Swimming	
Wrestling	Softball	Tennis	
	Volleyball	Track	

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.

Effects of physiologic maneuvers on heart sounds:

Standing	Increases murmur of HCM Decreases murmur of AS, MR MVP click occurs earlier in systole
Squatting	Increases murmur of AS, MR, AI Decreases murmur of MCH MVP click delayed
Valsalva	Increases murmur of HCM Decreases murmur of AS, MR MVP click occurs earlier in systole

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 Cardio Myopathy

AS = Aortic Stenosis

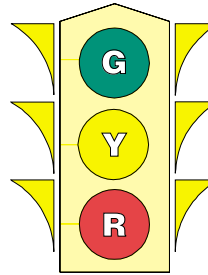
AI = Aortic Insufficiency

MR = Mitral Regurgitation

MVP = Mitral Valve Prolapse

Asthma Action Plan

The colors of a traffic light will help you use your asthma medicines.



Green means Go Zone!
Use preventive medicine.

Yellow means Caution Zone!
Add prescribed yellow zone medicine.

Red means Danger Zone!
Get help from a doctor.

Pay Attention to Symptoms.

(Press Firmly)

Name	Date of Birth	Effective Date / / to / /
Doctor	Parent/Guardian	
Doctor's Office Phone Number	Parent's Phone	
Emergency Contact After Parent	Contact Phone	

GO (Green)

You have all of these:

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

And/or Peak flow above _____

CAUTION (Yellow)

You have any of these:

- First sign of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

And/or Peak flow from _____ to _____

DANGER (Red)

Your asthma is getting worse fast:

- Medicine is not helping within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Lips blue
- Fingernails blue
- Trouble walking and talking

And/or Peak flow below _____

Use these medicines every day.

MEDICINE/DOSAGE	HOW MUCH TO TAKE	WHEN TO TAKE IT

COMMENTS:

For asthma with exercise, take:

--	--	--

Continue with green zone medicine and **ADD:**

MEDICINE/DOSAGE	HOW MUCH TO TAKE	WHEN TO TAKE IT
FIRST ➡		
NEXT ➡		

COMMENTS:

➡ **IF QUICK RELIEVER/YELLOW ZONE MEDICINE IS NEEDED MORE THAN 2-3 TIMES A WEEK THEN CALL YOUR DOCTOR.**

Take these medicines and call your doctor

EMERGENCY MEDICINE/DOSAGE	HOW MUCH TO TAKE	WHEN TO TAKE IT

COMMENTS:

Get help from a doctor now! It's Important!

Asthma is a potentially life threatening illness. If you cannot contact your doctor, go directly to the emergency room. **DO NOT WAIT.** Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

Check all items that trigger your asthma and things that could make your asthma worse:

- 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

This student is capable and has been instructed in the proper method of self-administering the medications named above (or attached prescription).

This student is not approved to self-medicate.

Check asthma severity: Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent

PHYSICIAN/IPA/APN SIGNATURE _____

PHYSICIAN STAMP _____

Approved by the New Jersey Thoracic Society,
Medical Section of the American Lung Association of New Jersey.

Adapted from the NYC Childhood Asthma Initiative
Adapted from the NHLBI

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