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:
         □ 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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</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):
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

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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

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**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: ________

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**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: ____________________________________________  Home Phone: ________________________________
City/State/Zip: ___________________________  District: ____________________________________________
School: ___________________________________________  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></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</td>
</tr>
<tr>
<td>Squatting makes it:</td>
<td>Louder</td>
<td>Softer</td>
</tr>
<tr>
<td>Valsalva makes it:</td>
<td>Louder</td>
<td>Softer</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>
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<tr>
<td>Evidence of Marfan Syndrome</td>
<td>ABSENT</td>
<td></td>
</tr>
</tbody>
</table>

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NJDOE/APPEF 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>
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</thead>
<tbody>
<tr>
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</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>LIMITED CONTACT</th>
<th>NON-CONTACT/STRENUEOUS</th>
<th>NON-CONTACT/NON-STRENUEOUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basketball</td>
<td>Baseball</td>
<td>Discus</td>
<td>Bowling</td>
</tr>
<tr>
<td>Diving</td>
<td>Cheerleading</td>
<td>Javelin</td>
<td>Golf</td>
</tr>
<tr>
<td>Field Hockey</td>
<td>Fencing</td>
<td>Shot put</td>
<td></td>
</tr>
<tr>
<td>Football</td>
<td>High Jump</td>
<td>Rowing</td>
<td></td>
</tr>
<tr>
<td>Ice Hockey</td>
<td>Pole vault</td>
<td>Running/Cross Country</td>
<td></td>
</tr>
<tr>
<td>Lacrosse</td>
<td>Gymnastics</td>
<td>Strength Training</td>
<td></td>
</tr>
<tr>
<td>Soccer</td>
<td>Skiing</td>
<td>Swimming</td>
<td></td>
</tr>
<tr>
<td>Wrestling</td>
<td>Softball</td>
<td>Tennis</td>
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<tr>
<td></td>
<td>Volleyball</td>
<td>Track</td>
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</tr>
</tbody>
</table>

**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
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: ________________________________________________________________

___________________________________________________________

___________________________________________________________