Sports Physicals: Everything you need to have your child cleared by the 1st day of practice!

West Essex Regional
School District
Athletic Department
Karen L Kinsey RN, BSN, CSN-NJ
West Essex High School

Athletics@westex.org

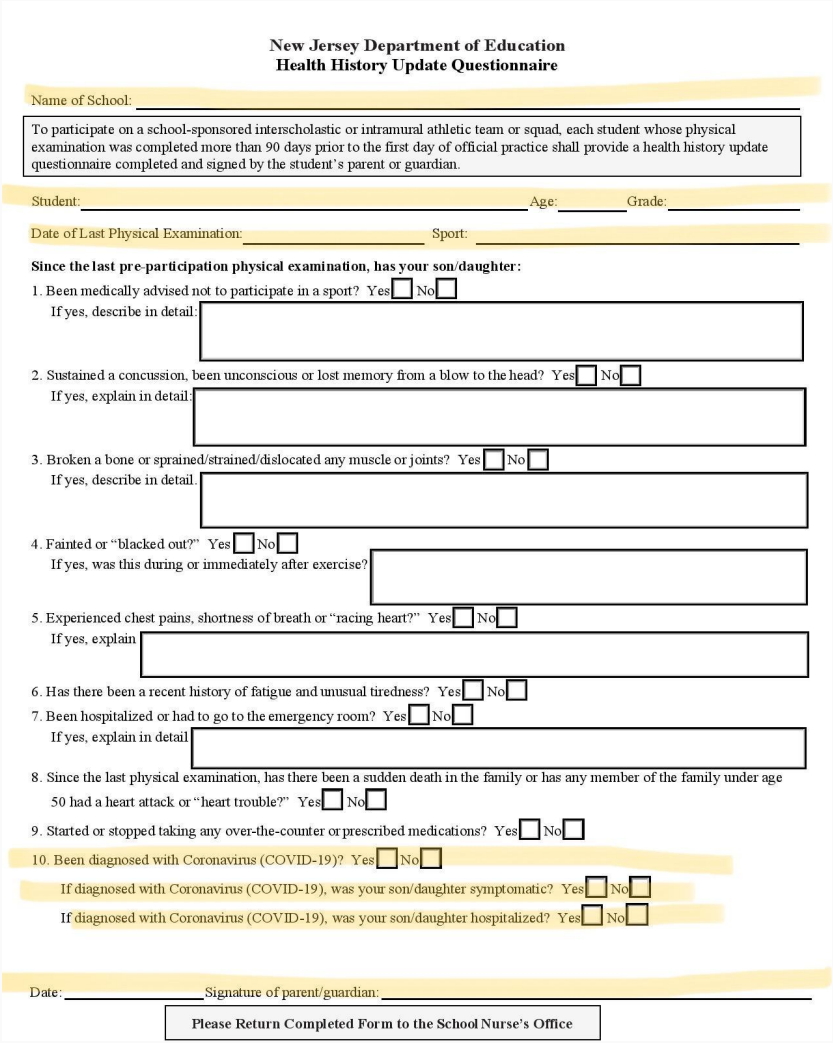
The Health History Update Questionnaire

REQUIRED FOR EVERY SEASON

- The highlighted areas must be completed
  - Name, Age, Grade
  - Last Physical Exam date
  - Sport being played that Season
  - Parent Signature and current date
  - Question 10 is required by the NJ DOE

If you are providing me with a new Physical Examination, LESS THAN 90 days old, you do NOT need to complete Questions 1-9

Questions 1-9 are asking if any of these incidents have happened since the LAST time your child has been seen & examined by a Licensed Healthcare Provider



New Jersey Department of Education
Health History Update Questionnaire

Name of School: _____

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student's parent or guardian.

Student: _____ Age: _____ Grade: _____

Date of Last Physical Examination: _____ Sport: _____

Since the last pre-participation physical examination, has your son/daughter:

1. Been medically advised not to participate in a sport? Yes ☐ No ☐
   If yes, describe in detail:
2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes ☐ No ☐
   If yes, explain in detail:
3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes ☐ No ☐
   If yes, describe in detail.
4. Fainted or "blacked out?" Yes ☐ No ☐
   If yes, was this during or immediately after exercise?
5. Experienced chest pains, shortness of breath or "racing heart?" Yes ☐ No ☐
   If yes, explain
6. Has there been a recent history of fatigue and unusual tiredness? Yes ☐ No ☐
7. Been hospitalized or had to go to the emergency room? Yes ☐ No ☐
   If yes, explain in detail
8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes ☐ No ☐
9. Started or stopped taking any over-the-counter or prescribed medications? Yes ☐ No ☐
10. Been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐
    If diagnosed with Coronavirus (COVID-19), was your son/daughter symptomatic? Yes ☐ No ☐
    If diagnosed with Coronavirus (COVID-19), was your son/daughter hospitalized? Yes ☐ No ☐

Date: _____ Signature of parent/guardian: _____

Please Return Completed Form to the School Nurse's Office

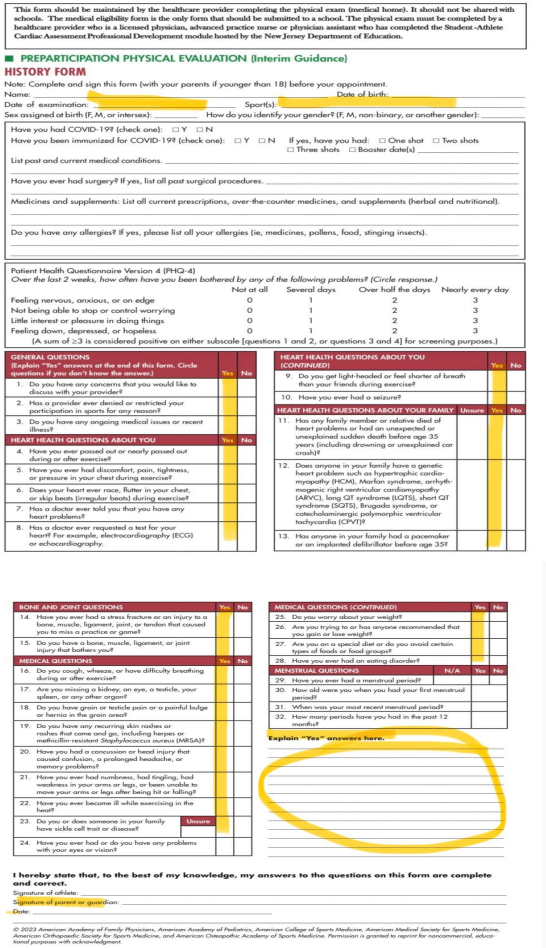
The Family History Pages

The Date of Examination must be COMPLETED!!!

If you answer YES to any of the questions, you must explain the YES answer in the box provided, on the bottom right corner of the page

The Student should sign the form, the Parent MUST sign & date the form!!!!

This form is to be completed by the Parents and Given to the Pediatrician



This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student-Athlete Cardiac Assessment Professional Development module hosted by the New Jersey Department of Education.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s) _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Unsure**	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
MENSTRUAL QUESTIONS	**N/A**	**Yes**	**No**
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

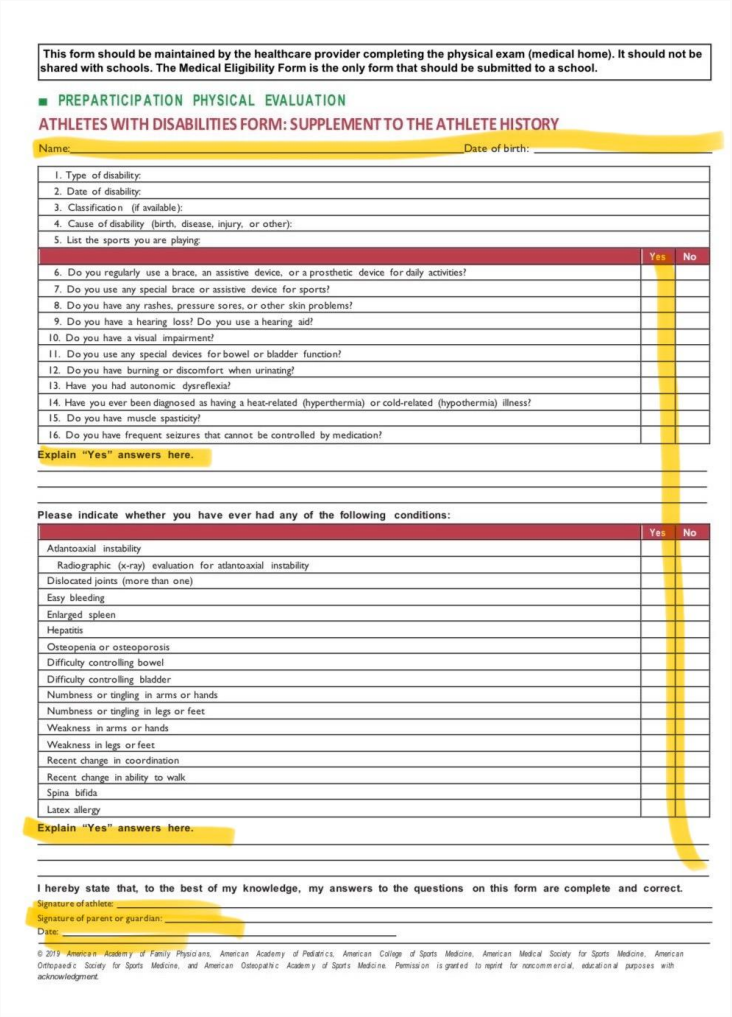
I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

Only complete and return this form if the student-athlete has special needs, otherwise you can disregard this page!



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■ PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: _____ Date of birth: _____

1. Type of disability:
2. Date of disability:
3. Classification (if available):
4. Cause of disability (birth, disease, injury, or other):
5. List the sports you are playing:

	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or 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 as having 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 whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (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 questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

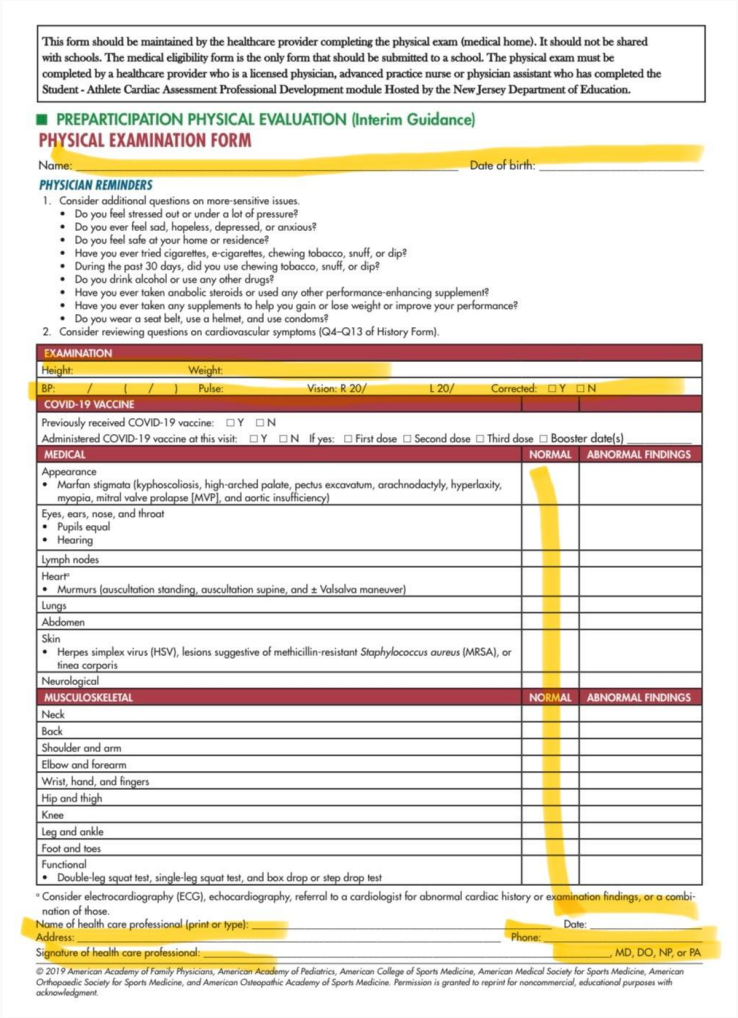
The Physical Examination Form

Please put your child's name and date of birth ON EACH PAGE

- Physical Examination
  - Height & Weight
  - Blood Pressure
  - Vision Screening, even if your child wears glasses, I need the exam done. I do have a form for the Eye Doctor if needed
  - Cleared/Not Cleared for Participation
  - HCP Signature and Date

The State of NJ Department of Education wants this form to stay with the Pediatrician.

If the office gives it back to you, please hand it in with the other paperwork



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■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

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, e-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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N		
Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) _____		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

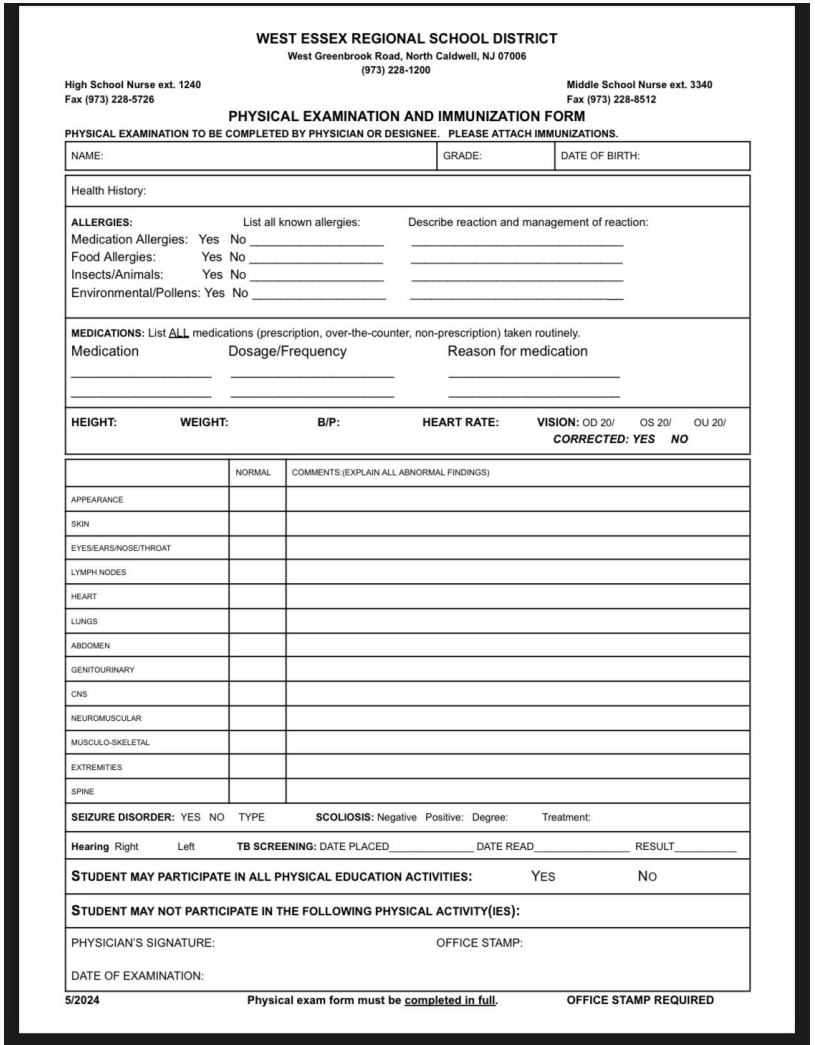
Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

Physical Examination and Immunization Form

This form is required to be handed in with the Sports Physical form or your child will not be in compliance and your child's physical will NOT be processed for Medical Clearance!

This form must be completed in its entirety with a doctor's signature, Date of Exam and Office Stamp



WEST ESSEX REGIONAL SCHOOL DISTRICT
West Greenbrook Road, North Caldwell, NJ 07006
(973) 228-1200

High School Nurse ext. 1240
Fax (973) 228-5726

Middle School Nurse ext. 3340
Fax (973) 228-8512

PHYSICAL EXAMINATION AND IMMUNIZATION FORM

PHYSICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN OR DESIGNEE. PLEASE ATTACH IMMUNIZATIONS.

NAME:	GRADE:	DATE OF BIRTH:

Health History:

ALLERGIES: List all known allergies: Describe reaction and management of reaction:

Medication Allergies: Yes No _____ _____
Food Allergies: Yes No _____ _____
Insects/Animals: Yes No _____ _____
Environmental/Pollens: Yes No _____ _____

MEDICATIONS: List ALL medications (prescription, over-the-counter, non-prescription) taken routinely.

Medication	Dosage/Frequency	Reason for medication

HEIGHT: **WEIGHT:** **B/P:** **HEART RATE:** **VISION:** OD 20/ OS 20/ OU 20/
CORRECTED: YES NO

	NORMAL	COMMENTS:(EXPLAIN ALL ABNORMAL FINDINGS)
APPEARANCE		
SKIN		
EYES/EARS/NOSE/THROAT		
LYMPH NODES		
HEART		
LUNGS		
ABDOMEN		
GENITOURINARY		
CNS		
NEUROMUSCULAR		
MUSCULO-SKELETAL		
EXTREMITIES		
SPINE		

SEIZURE DISORDER: YES NO TYPE **SCOLIOSIS:** Negative Positive: Degree: Treatment:

Hearing Right Left **TB SCREENING:** DATE PLACED_____ DATE READ_____ RESULT_____

STUDENT MAY PARTICIPATE IN ALL PHYSICAL EDUCATION ACTIVITIES: YES NO

STUDENT MAY NOT PARTICIPATE IN THE FOLLOWING PHYSICAL ACTIVITY(IES):

PHYSICIAN'S SIGNATURE: OFFICE STAMP:

DATE OF EXAMINATION:

5/2024 **Physical exam form must be completed in full.** **OFFICE STAMP REQUIRED**

Medical Eligibility Form

Please put your child's name and date of birth & DATE OF EXAM on this Page

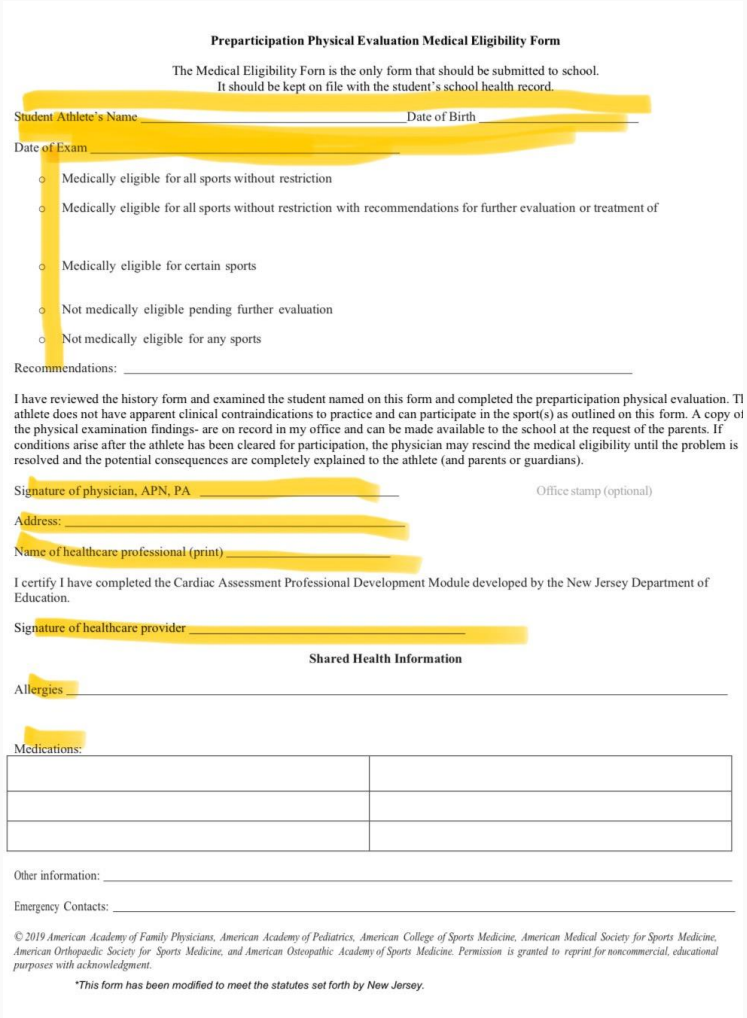
DO NOT LEAVE THE DOCTOR'S OFFICE IF THE HIGHLIGHTED AREAS ARE NOT COMPLETED!!!

Medically Eligible for all Sports w/o Restrictions

Healthcare Provider's Office STAMP

Healthcare Provider's Signature and Date

- CARDIAC ASSESSMENT MODULE
  - HCP Signature
  - Date HCP completed the Module that is required in the State of NJ to perform Sport Physicals, will never be the same date the exam is being done!



Preparticipation Physical Evaluation Medical Eligibility Form

The Medical Eligibility Forn is the only form that should be submitted to school.
It should be kept on file with the student's school health record.

Student Athlete's Name _____ Date of Birth _____

Date of Exam _____

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of
- Medically eligible for certain sports
- Not medically eligible pending further evaluation
- Not medically eligible for any sports

Recommendations: _____

I have reviewed the history form and examined the student named on this form and completed the preparticipation physical evaluation. Tl
athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of
the physical examination findings- are 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 medical eligibility until the problem is
resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Signature of physician, APN, PA _____ Office stamp (optional)

Address: _____

Name of healthcare professional (print) _____

I certify I have completed the Cardiac Assessment Professional Development Module developed by the New Jersey Department of Education.

Signature of healthcare provider _____

Shared Health Information

Allergies _____

Medications:

Other information: _____

Emergency Contacts: _____

**This form has been modified to meet the statutes set forth by New Jersey.*

If your child has ***Asthma*

Or a ***Life Threatening Allergy*** requiring

an ***Epinephrine Pen*** or requires

a ***Seizure Action Plan*** **

Your Child's Physical Examination will not be processed for Medical Clearance by our School Physician if I do not have a copy of those forms on file in the Nurse's Office!

These orders expire on the Last Day of the School Year Per NJ Statute!

- ***PLEASE submit all forms at least 10 DAYS prior to the 1st day of practice***
- Once all forms are completed and handed into the Nurse's Office, They must be reviewed by the Nurse to ensure all required areas are completed.
  - A WE Clearance form is completed and attached to the physical paperwork.
  - The Physicals are DRIVEN to the School Physician's Office and are left for doctor to review.
  - Once reviewed and Medically Cleared by the School Physician, we are notified the physicals are ready to be picked up. The someone DRIVES back to the Doctor's Office to retrieve them.

The NJSIAA requires we employ a School Physician to provide MEDICAL CLEARANCE, this does not come from YOUR Doctor.

Notification of Medical Clearance

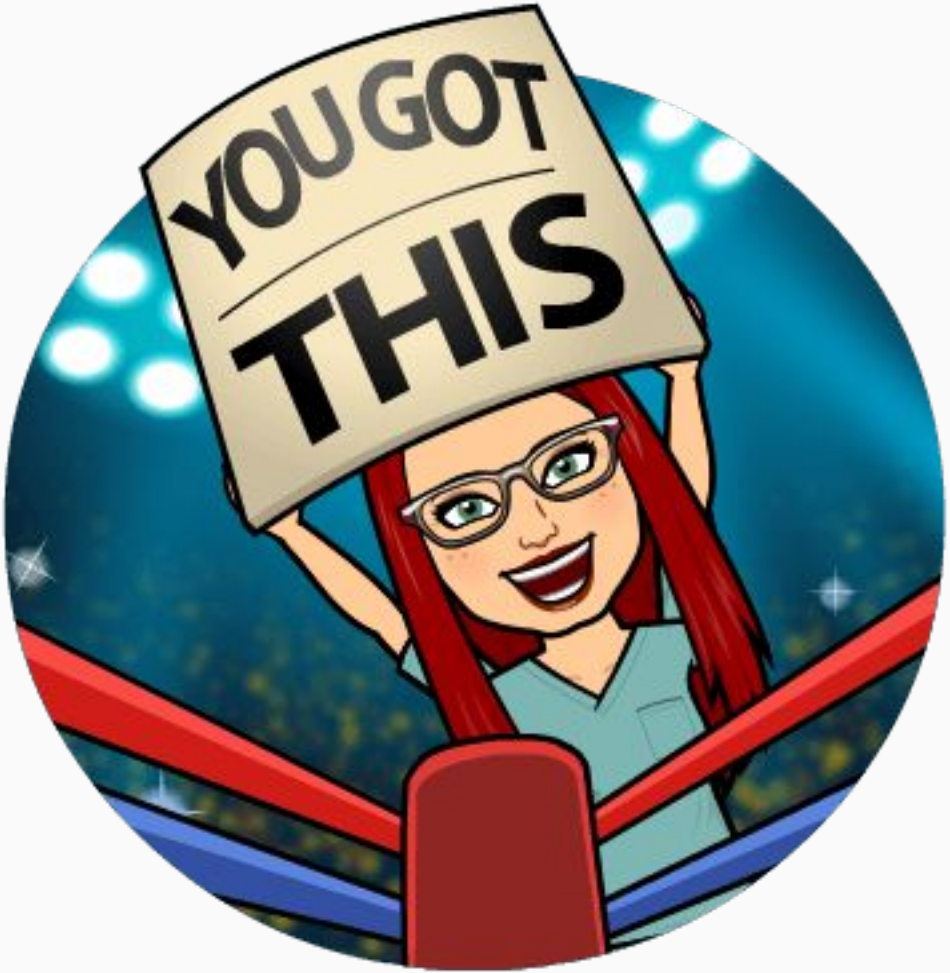
- The Nurse scans the signed Clearance Form into Genesis and You will receive a Notification that there is a New Nurse Form in Genesis to view.

- This is how you are notified of Medical Clearance, we will NOT contact individual parents unless there is a problem with their clearance and we will NOT answer emails regarding Clearance, we average 100 emails a day during clearance time.

You MUST ENABLE Notifications in Genesis

- West Essex Athletics by Season

Fall	~600 Student Athletes
Winter	~400 Student Athletes
Spring	~500 Student Athletes


YOU GOT
THIS