Cape May County Technical High School
Medical Clearance to Participate in High School Sports and Intramural Sports:
New Jersey Administrative Code N.J.A.C.6A:16-2.2

Instructions for completing the medical clearance forms for sports:

1. **Preparticipation Physical Evaluation: HISTORY FORM** (Page 2 is required if your child has any special needs as indicated on form.)

   Parent/Guardian AND Student must sign at the indicated areas.

2. **Preparticipation Physical Evaluation: Physical Examination Form** (2 pages)

   MAKE SURE THAT A PHYSICIAN, NURSE PRACTITIONER OR CERTIFIED PHYSICIAN'S ASSISTANT ENTERS ALL INFORMATION ON THE PHYSICAL EXAMINATION FORM. DO NOT LEAVE ANY INFORMATION BLANK.

PRINT ATHLETES NAME: _____ **D.O.B.**___/___/___ **Grade:** _____

☐ **Attached are my child's Preparticipation Physical Evaluations:**

☐ **Health History (1 page)**
...*and if indicated* **for a child with a disability or other health problem:**
☐ **The Athlete with Special Needs Health History**

☐ **Physical Examination Forms (2 pages) –**
Be sure the physician, APN or PA stamped/signed both pages:
"Physical Examination Form" and "Clearance Form"
Note: Two signatures are now required on page 2 "Clearance Form".
(the Physical Exam statement AND the Cardiac Professional Development)

My child and I have completed and signed the following additional forms:

☐ **Student and Parent Consent Form**

☐ **Sign-Off Form – Consent for Drug Testing, Sudden Cardiac Death in Young Athletes, Sports Related Concussion - Head Injury Fact Sheet, and Sports Related Eye Injuries.**

Parent/Guardian: Submit this packet to the School Nurse.
If your child does not have health insurance or a medical provider please call the school nurse at 465-2161 ext. 658 to arrange for an appointment with the school physician. The school physician is available once each sport season so call early if you do not have health insurance. All attached forms must be completed except for the "Preparticipation Physical Evaluation: Physical Examination Form".

CAPE MAY COUNTY TECHNICAL HIGH SCHOOL ATHLETIC DEPARTMENT
STUDENT AND PARENT CONSENT FORM

PLEASE PRINT

Complete Legal Name: _____ _____ _____
(First) (Middle) (Last)

Address:_____ Telephone:_____

Date of Birth____/____/____ Place of birth: _____ Grade:____ **Sport trying out for:**_____

STUDENT PARTICIPATION

This application to participate in athletics at Cape May County Technical High School is voluntary on my part and is made with the understanding that I will abide by all the eligibility rules set up by the New Jersey State Interscholastic Athletic Association and Cape Atlantic League, and receive prior to play a physical examination.

Signature of Student:_____ **Date:** _____

PARENT OR GUARDIAN CONSENT

I hereby give my consent for the above high school student to engage in interscholastic athletics at Cape May County Technical High School for the above sport during the current school year and to accompany the team as a member on its out-of-district trips. I understand that my son/daughter will be expected to adhere firmly to all established athletic policies, and eligibility rules, and receive prior to play, a physical examination.

Signature of Parent or Guardian:_____ **Date:** _____

****

EMERGENCY INFORMATION AND MEDICAL TREATMENT CONSENT

(To be completed by parent)

In emergency, contact _____ Phone _____, or
_____ Phone _____.

I,_____, the parent or guardian of the above high school student recognize that as a result of interscholastic athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. Therefore, I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstance. Please make the following notations on my son's/daughter's records:

Medication allergies: List _____Food/insect allergies: List_____If yes, does

your child require emergency medication? NO YES (Name of medication):_____

Other relevant medical information (e.g., glasses, contact lenses; prior surgeries, epilepsy; heart murmur, diabetes, seizure disorder, etc.) _____

Medication for long-term or chronic illness (indicate physical or mental health condition and medications):

_____

Signature of Parent or Guardian:_____ Date _____

****

Athletic Director Approval:_____ **Health Office Approval:**_____**Restrictions:** _____

Eye protection (rec specs) due to vision problem: Eye effected: R L Both Condition: _____

Coach: provide athlete with attached agreement (PINK PAPER) "Athletes with": Asthma Life-Threatening Allergies Diabetes

Individual Emergency Health Care Plan provided for: Asthma Diabetes Life-Threatening Allergy Other: _____

Note for Coach: See school nurse for training and questions regarding athlete's medical condition.

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

Explain "Yes" answers below. Circle questions you don't know the answers to.

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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ 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: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ 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 _____

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HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

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 _____

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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 ☐ Y ☐ 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[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]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]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 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/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)_____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

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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 _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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, 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 _____

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Cape May County Technical High School
This page must be signed by student athlete and parent/guardian prior to participation in school athletic or intramural programs.

Student-Athlete Name (PRINT): _____

Parent/Guardian Name (PRINT): _____

New Jersey State Interscholastic Athletic Association (**NJSIAA**)

STEROID TESTING POLICY AND CONSENT TO RANDOM TESTING

Any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances listed on the attached page, without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition. The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents, and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing. By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

_____ ___/___/___
Signature of parent/guardian Date

_____ ___/___/___
Signature of Student-Athlete Date

Information regarding: Sudden Cardiac Death, Concussion, and Eye Injury

I/We acknowledge that we reviewed the following information (available on school website).

Sudden Cardiac Death in Young Athletes - http://www.capemaytech.com/CardiacPamphlet.pdf

Sports Related Concussion and Head Injury - http://www.capemaytech.com/ConcussionHeadInjuryFactSheet.pdf

Sports Related Eye Injury - http://www.capemaytech.com/sportsrelatedeyeinjury.pdf

Signature of parent/guardian: _____

I do not have access to the internet and request paper copies of the above information. Send me paper copies of the above information home with my son/daughter.

Parent/Guardian:

☐ (*Check box only if you need paper copies of the above pamphlets.)*

****

***School Nurse**: If box is checked provide the printed handouts to the student-athlete. Date printed: ____/____/____*

Attachment: NJSIAA Banned-Drug Classes 2006 - 2007

State of New Jersey
DEPARTMENT OF EDUCATION

HEALTH HISTORY UPDATE QUESTIONNAIRE

Name of School Cape May County Technical High 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____
9. Started or stopped taking any over-the-counter or prescribed medications? Yes____ No____
   If yes, name of medication(s)_____

Date:_____ **Signature of parent/guardian** _____

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE'S OFFICE

E14-00284