**BLACK HORSE PIKE REGIONAL SCHOOL DISTRICT**

Triton ● Highland ● Timber Creek

Please be sure to complete the following checklist in its entirety, otherwise this athletic physical packet will not be considered “complete” and ready for review by the school physician and/or school nurse:

 [**www.FamilyID.com**](http://www.FamilyID.com/) – Online athletic participation registration. This registration MUST be completed by ALL athletes and done so for EVERY season, EVERY school year. Student-athlete eligibility will NOT be verified without the completion of this process.

 **ImPACT Test** – Computerized baseline concussion testing. Required test to be completed by ALL athletes and shall be valid for 2 years from the date of initial testing.

 **Physical Evaluation History Form** – this form is 2 pages and should be completed by the parent/guardian. Page 2 is only to be completed if the athlete has special needs.

 **Physical Examination Form** – this form is also 2 pages and must be completed by the athlete’s family physician. ***\*IT IS IMPERATIVE THAT ALONG WITH THE PHYSICIAN ’S SIGNATURE & STAMP ON PAGE 1 OF THIS FORM, THAT THE PHYSICIAN ALSO SIGNS AND ACKNOWLEDGES THE***

***“C ARDIAC ASSESSMENT PROFESSIONAL MODULE” AT THE BOTTOM OF***

***PAGE 2 OF THIS FORM***

 **Medication Dispensing Form** – this form shall be completed if the athlete is prescribed an inhaler or epi-pen, and must be completed by the parent/guardian and family physician.

\*Please be aware that completing the online registration process and physician’s physical exam does NOT

guarantee the athlete’s eligibility. Eligibility is contingent upon:

 Completed physical packet paperwork

 A valid physical (good for 365 days)

 Academic requirements/credits

 Behavioral/conduct requirements

 No outstanding fines

[**Family**](http://www.familyid.com/) **ID Registration**

FamilyID is a secure registration platform that provides you with an easy, user- friendly way to register for our athletic program, and helps us to be more administratively efficient and environmentally responsible. When you register through FamilyID, the system keeps track of your information in your FamilyID profile so you enter your information only once for multiple uses, multiple family members and multiple sports programs.

It will be helpful to have the following information handy to allow for accurate completion of your online registration.

 Doctor information; health insurance information; emergency contact information

A parent/guardian should register by going to: [https://www.familyid.com/black- horse-pike-regional-school-district](https://www.familyid.com/black-horse-pike-regional-school-district). Directions can be found in the “Links” section located on the right side of the FamilyID/Black Horse Pike home page.

If you need assistance with you registration, you can call Family ID at 888-800-

5583 x1 or em[ail support@familyid.com.](mailto:support@familyid.com) FamilyID also offers online chat during business hours and a support center.

**\*FamilyID registration MUST be done completed by ALL athletes for EVERY season. Registrations do not carry over from sport to sport\***



**Black Horse Pike Regional School District**

580 Erial Road, Blackwood, NJ 08012

**ImPACT**

All athletes must complete baseline ImPACT testing before being allowed to participate in their sport. ImPACT is a computerized concussion evaluation system that measures verbal and visual memory, processing speed and reaction time. To most effectively

care for athletes who have sustained concussions, it is helpful to compare baseline data to post-concussion data so that any deficits can be determined and proper return-

to-play decisions can be made.

**INSTRUCTIONS FOR ATHLETES**

Please understand that you cannot “fail” this test. It is extremely important, however, that you:

1. Set aside 30 minutes in a quiet place with **NO DISTRACTIONS**.

2. **READ** the instructions very carefully. Failure to do this can affect the test results and you may then have to re-take the test.

3. If you do not have Internet access at home and are unable to take the test anywhere else, please contact your certified athletic trainer.

**TO TAKE TO THE TEST:**

1. Go to Internet Explorer or other web browser

2. Type in the website: [www.impacttestonline.com/schools/](http://www.impacttestonline.com/schools/)

3. Select “New Jersey”

4. Launch baseline test

5. Follow the directions. Make sure to read all instructions!

**TCHS Customer ID Code: 542D7DC4DA HHS Customer ID Code: ADDB273F4E THS Customer ID Code: 44907883D4**

**ANY QUESTIONS OR CONCERNS SHOULD BE DIRECTED**

**TO YOUR SCHOOL’S CERTIFIED ATHLETIC TRAINER LISTED BELOW.**

**Highland Regional High School**

Athena DeAngelis

(856) 227-4100, ext. 4100 [adeangelis@bhprsd.org](mailto:%20adeangelis@bhprsd.org)

**Timber Creek Regional High School**

Dominic Acchitelli

(856) 232-9703, ext. 6050 [dacchitelli@bhprsd.org](mailto:dacchitelli@bhprsd.org)

**Triton Regional High School**

Rachel Pantaleo

(856) 939-4500, ext. 2078 [rpantaleo@bhprsd.org](mailto:%20rpantaleo@bhprsd.org)

■ Preparticipation Physical Evaluation

HISTORY FORM

(Note: This form is to be flled 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.

|  |  |  |
| --- | --- | --- |
| 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

|  |  |  |
| --- | --- | --- |
| 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? |  |  |

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

■ Preparticipation Physical Evaluation THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

ONLY use this form for disablities.

DO NOT use for injuries.

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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PHYSICAL EXAMINATION FORM

Name

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?

Date of birth

• 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).

**Physician/Provider's Stamp**

|  |  |  |
| --- | --- | --- |
| 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 |  |  |

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 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).

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 condi- tions 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).

Na�e of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) - Date

Address Phone

Signature of physician, APN, PA @@@@@@@@

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Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

HE0503 9-2681/0410

**CLEARANCE FORM**

Name

0 Cleared for all sports without restriction

Sex 0 M 0 F Age

Date of birth

0 Cleared for all sports without restriction with recommendations for further evaluation or treatment for

0 Not cleared

0 Pending further evaluation

0 For any sports

0 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, "1/, 1" @ @@@@@@@@\_

Completed Cardiac Assessment Professional Development Module

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**This page Is to be completed by Parent/Guardian and Physician**

**Form 4**

Black Horse Pike Regional School District -Medication- Dispensing Form

List only one medication on a form, additional forms available upon request.

P·. ,·

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f;,.'.

*PARENTS SHOULD FILL OUT THE BOLDED AREAS*

I request the enclosed medication, in the original container, to be administered to *my* child and shall release school personnel from all liability. I give the School Nurse permission to contact the physician and/or pharmacist with any quesllon concerning the medication.

Name of Child

Name & Strength of Medication

Dosage

Signature of Parent/Guardian *X*

·• e:-·-· ··*j* ·

:11

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D. .

|  |  |  |
| --- | --- | --- |
| *DOCTORS MUST COMPLETE* All *BOLD ED INFORMATION*  Students Name Age Grade School  Name & Strength of Medication Dosage  Time & Route of Administration In School Reason for Medication . Effective Dates: from to  Most common side effects:  It Is my understanding the School Nurse charged with the administration of medication may rely upon my direction as contained in this document. I further certify that I om the physician who prescribed the medication and that the  student named above is under my supervision as a patient for diagnosis and treatment. Any alteration to the above  *X*  Doctor's Name (Print) Doctor's Signature    Patient's Medication Allergies Doctor's Address  Date Doctor's Telephone Number  " .. ,..,..,...,. =,... ··- . ·-"""' ,,,................ ,.,.,..... | | |
|  | ***INHALER AND EP/-PEN PATIENTS ONLY***  I certify that the pupil has asthma or another life threatening illness and is capable of, and has b the proper method of self-administration of medication.  In case of ASTHMA or potentially life threatening illness, will the student be giving himself/herself thi  DYes D No *X*  Doctor's Signature | een Instructed in, s medication( |
| REQUIRED |

-· -- ··-..... -· """ . . .,.....,., ·-

*INHAlER AND EPI·PEN PATIENTS ONLY*

In case of ASTHMA or potentially life threatening Illness,will the student be giving himself/herself this medication

DYes D No If yes, please sign below

We the parents *or* guardians of the pupil, acknowledge that the district shall incur no liability as a result of any injury arising from the self-administration of medication by the pupil and that we shall indemnify and hold harmless the district and Its employees or agents against any claims arising out of the self-administration of medication by the pupil. The permission is effective for the school year for which it is granted.

Signature of Parent/Guardian *X* Date

Both sections must have completed information and required signatures.

- ,\_,

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will occur only with written directions from the attending physician.

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