

ATHLETIC PREPARTICIPATION PARENT LETTER & CHECK LIST

New Jersey State Law mandates that the school physician must clear all sports physicals prior to the start of each season. Students will not be allowed to participate in interscholastic sports (including tryouts and practices) until the school physician has cleared the student's sports physical. It is imperative that all paperwork is completed and returned in a timely manner to ensure approval and eligibility for participation. **All completed paperwork must be brought directly to the Long Valley Middle School.**

Listed below are the forms that need to be completed prior to the start of the sports season (signatures are required on all forms): Use this checklist to ensure you have gathered and signed all necessary forms.

PreParticipation Physical Evaluation Forms (Physical Forms):

- 1. **HISTORY FORM** - (Must be attached with the physical examination and **current within 365 days**)
 - entire form must be filled out and signed by the parent
 - any "yes" answers to questions 1-54 must be explained at bottom right of the form
 - the form must be signed by the Parent and Athlete
- 2. **PHYSICAL EXAMINATION FORM** - (Physicals must be **current within 365 days**)
 - The Date of Exam must be filled in at the top of the physical and the physical must not expire before the start of the season
 - Height, Weight, Blood Pressure, Pulse, Review of Systems, and Clearance Level must be filled in by the physician
 - Vision must be completed and documented by the physician or an ophthalmologist's report must be attached.
 - Physicians must sign and stamp the Physical Examination Form
- 3. **HEALTH HISTORY UPDATE**- (Complete at the **start of each season**)
 - Required prior to the start of each season.
- 4. Athletic Sign-Off Sheet (all **four** sections must be signed by parent and athlete)
 - **Educational Fact Sheets can all be found online**
- 5. Sports Permission Consent Sign-Off (signed by parent and athlete) complete for **EACH** sport
- 6. Additional forms are required for students who have been diagnosed with Asthma (Asthma Action Plan),
 - Life-Threatening Allergies (Anaphylaxis Action Plan), and other Medical Conditions; these forms are due yearly.

All sports forms are available on the **Long Valley Middle School Website** under the **For Students** tab, click on **Athletics**, and **Sports Forms**. *Asthma Action Plan* and *Anaphylaxis Action Plan* are located under the **For Parents** tab, then click on **District Forms**. If you have questions regarding the sports medical clearance process contact Mrs. Nancy Meara 908-876-3434 ext. 2306.

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	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
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)?			40. Have you ever become ill while exercising in the heat?		
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?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
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)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			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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**PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS:
SUPPLEMENTAL HISTORY FORM**

(Optional)

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		
6. Do you regularly use a brace, assistive device, or prosthetic?	Yes	No
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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State of 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, describe 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 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 _____
If yes, name of medication _____

Date: _____ Signature of parent/guardian _____

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE'S OFFICE

Mr. Mark Ippolito, Principal
Mrs. Danielle Schweitzer, Assistant Principal

Phone: 908-876-3434
Fax: 908-876-3436

SPORTS/ELIGIBILITY PERMISSION CONSENT

Sign-Off Sheet

*****Please fill one form out for EACH sport*****

I, along with my son/daughter, whose signature appears below, acknowledge that we have read the Washington Twp. Schools Extracurricular Activities eligibility Policy and agree to adhere to all rules as outlined in the Policy.

I, along with my son/daughter, whose signature appears below, acknowledge the physical hazards that may be encountered in sports activities, and I give permission for him/her to try out for, _____ and be transported to and from any away competition(s).
(list one sport, a new form must be completed for EACH sport)

Student Signature: _____

Print Student's Name: _____

**Parent or Guardian
Signature:** _____

**Print Parent or Guardian's
Name:** _____

Date: _____

Mr. Mark Ippolito, Principal
Mrs. Danielle Schweitzer, Assistant Principal

Phone: 908-876-3434
Fax: 908-876-3436

Athletic Sign-Off Sheet

SPORTS-RELATED CONCUSSION AND HEAD INJURY FACT SHEET

N.J.S.A. 18A:40-41.2 requires public schools to distribute an annual educational fact sheet on sports-related concussion and head injury to the parents/guardians of students participating in interscholastic sports and cheerleading, and to obtain a signed receipt.

I/We have completely read and fully understand the provided information sheets for the parent and athlete. I understand the risks of playing a sport in addition to understanding the risks of continuing to play while recovering from a concussion. I (the athlete) agree to notify my coaches if I experience any of the symptoms listed on the concussion fact sheet prior to returning to participation.

Student Signature: _____ **Print Student's Name:** _____

Parent or Guardian **Print Parent or Guardian's**

Signature: _____ **Name:** _____

USE AND MISUSE OF OPIOID DRUGS FACT SHEET

In accordance with N.J.S.A. 18A:40-41.10, public school districts participating in an interscholastic sports program must distribute the Opioid Use and Misuse Education Fact Sheet to all student-athletes and cheerleaders. In addition, school and district must obtain a signed acknowledgement of receipt of the fact sheet from each student-athlete and cheerleader and for students under age 18, the parent or guardian must also sign.

I/We acknowledge that we received and reviewed the *Educational Fact sheet on the Use and Misuse of Opioid Drugs*.

Student Signature: _____ **Print Student's Name:** _____

Parent or Guardian **Print Parent or Guardian's**

Signature: _____ **Name:** _____

SPORTS-RELATED EYE INJURIES FACT SHEET

N.J.S.A. 18A: 40-41.9b requires this educational fact sheet on sports-related eye injuries to be distributed annually by each school district and nonpublic school to the parents/guardians of its student-athletes.

I/We acknowledge that we received and reviewed the Sports-Related Eye Injuries Fact Sheet.

Student Signature: _____ **Print Student's Name:** _____

Parent or Guardian **Print Parent or Guardian's**

Signature: _____ **Name:** _____

SUDDEN CARDIAC DEATH PAMPHLET

This pamphlet must be distributed to each student-athlete and to the parents/guardians of the student-athletes, pursuant to N.J.S.A. 18A:40-41c-d.

I/We acknowledge that we received and reviewed the Sudden Cardiac Death in Young Athletes pamphlet.

Student Signature: _____ **Print Student's Name:** _____

Parent or Guardian **Print Parent or Guardian's**

Signature: _____ **Name:** _____