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 ____________________________ 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

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 □ Diabeties □ 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/ECG, echocardiogram) __________

10. Do you get light headed 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 shoulder instability? (Down syndrome or dwarfish) __________

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 been treated with a 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 (male), your spleen, or any other organ? __________

30. Do you have joint pain or a painful boil or hernia in the groin area? __________

31. Have you had infectious mononucleosis (monon) 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 III 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: ____________________________


9-360340410

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 ________________________________ Date of birth __________
Name ___________________________________________ Grade ____________
Sex ____________________________ Age ____________ School ____________________________

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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Do you regularly use a brace, assistive device, or prosthesis?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you use any special brace or assistive device for sports?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Do you have any rashes, pressure sores, or any other skin problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you have a visual impairment?</td>
<td></td>
<td></td>
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<tr>
<td>11. Do you use any special devices for bowel or bladder function?</td>
<td></td>
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<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
<td></td>
<td></td>
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<tr>
<td>13. Have you had autonomic dysreflexia?</td>
<td></td>
<td></td>
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<tr>
<td>14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
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<td></td>
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<tr>
<td>15. Do you have muscle spasticity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explain "yes" answers here

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please indicate if you have ever had any of the following.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enlarged spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteopenia or osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
<td></td>
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<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
<td></td>
<td></td>
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<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spina bifida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex allergy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 __________

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

## Physical Examination Form

### 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

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
<th>Pulse</th>
<th>Vision R 20'</th>
<th>L 20'</th>
<th>Corrected</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

### Medical

- **Appearance**
  - Marfan stigmata (eyeholoccolosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyper弹, myopia, MVP, aortic insufficiency)

- **Eyes/ears/nose/throat**
  - Pupils equal
  - Hearing

- **Lymph nodes**

- **Heart**
  - Murmurs (auscultation standing, supine, +/- Valsalva)
  - Location of point of maximal impulse (PMI)

- **Pulses**
  - Simultaneous femoral and radial pulses

- **Lungs**

- **Abdomen**

- **Genitourinary (males only)**

- **Skin**
  - HfD lesions suggestive of MRSA, fixed lesions

- **Neurologic**

### Musculoskeletal

- **Neck**
- **Back**
- **Shoulder/arm**
- **Elbow/forearm**
- **Wrist/hand/fingers**
- **Hip/thigh**
- **Knee**
- **Leg/ankle**
- **Foot/toes**

- **Functional**
  - Duck-walk, single leg hop

### Recommendations

- **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 ____________

### Recommendations

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present any 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 ____________

BRIARCLIFF MIDDLE SCHOOL

Preparticipation Physical Evaluation Clearane 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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