NOTES TO THE EXAMINING PROVIDER

Conditions requiring clearance before sports participation include, but are not limited to the following:

Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heat murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; Seizure Disorder; Marfan Syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-Strenuous
Basketball	Baseball	Discus	Bowling
Diving	Cheerleading	Javelin	Golf
Field Hockey	Fencing	Short Put	
Football	High Jump	Rowing	
Ice Hockey	Pole Vault	Running/Cross Country	
Lacrosse	Gymnastics	Strength Training	
Soccer	Skiing	Swimming	
Wrestling	Softball	Tennis	
	Volleyball	Track	

N.J.A.C. 6A:16-2.2 requires the school physician to provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this physical evaluation. This evaluation and the notification letter become part of the student's school health record.

Effects of physiologic maneuvers on heat sounds:

Standing	Increases murmur of HCM Decreases murmur of AS, MR MVP click occurs earlier in systole
Squatting	Increases murmur of AS< MR< AI Decreases murmur of MCH MVP click delayed
Valsalva	Increases murmur of HCM Decreases murmur of AS, MR MVP click occurs earlier in systole

HCM = Hypertrophic Cardio Myopathy
AS = Aortic Stenosis
AI = Aortic Insufficiency
MR = Mitral Regugitation
MVP = Mitral Valve Prolapse

Physical Stigmata of Marfan's Syndrome:

Kyphosis
High arched palate
Pectus excavatum
Arachnodactyly
Arm Span>height 1.05:1 or greater
Mitral Valve Prolapse
Aortic Insufficiency
Myopia
Lenticular dislocation

CLEARANCES: (See notes at bottom for conditions requiring attention and for a list of sports by level of contact)

☐ A. Student is cleared for participation in all sports without restriction

☐ B. Student is withheld clearance for participation in any sport until evaluation/treatment of:

_____

_____

_____

☐ C. Student is cleared for participation in limited types of sports which exclude the following types of sports contact: (CHECK ALL THAT APPLY)

____ CONTACT/COLLISION
____ LIMITED CONTACT
____ NON-CONTACT/STRENUOUS
____ NON-CONTACT/NON-STRENUOUS

Due to:

_____

HISTORY REVIEWED AND STUDENT EXAMINED BY:

Primary Care Provider ☐
School Physician Provider ☐
License Type:
MD/DO ☐
APN ☐
PA ☐

Physician's/Provider's Stamp:

PHYSICIAN'S/PROVIDER'S SIGNATURE:_____ Today's Date:_____

Date of Exam:_____

HISTORY REVIEWED BY:

Name _____ Today's Date:_____

Signature:_____ Review Date: _____

RESERVED FOR SCHOOL DISTRICT USE

Most recent immunizations and dates administered:

Medications currently prescribed with dose and frequency:

Medication Name	Dosage	Frequency

Additional observations:

General Diagnosis:

General Recommendations:

THE HISTORY PREPARED BY THE PARENT/STUDENT MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE PHYSICAL EXAMINATION.

School _____

Sport: _____

WW-P REGIONAL SCHOOL DISTRICT HEALTH FORM

Part B: Physical Evaluation Form

(Completed by the examining licensed provider MD, DO, APN or PA)

Student's Name: _____ Sex: M F (circle one) Age: _____ Grade: _____

Date of Birth: _____ Home Phone: _____

Address: _____

Street City State Zip

Parent/Guardian's Full Name _____

EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION

If conducted by school physician check here ☐

Name: _____ Phone: _____ Fax: : _____

Address: _____

FINDINGS OF PHYSICAL EVALUATION

Height: _____ Weight: _____ Blood Pressure: _____/_____ Pulse: _____bpm

Vision: R 20/____L20/____ Contacts: Y/N Glasses: Y/N

INDICATORS	NORMAL?	ADNORMAL FINDINGS/COMMENTS			
General Appearance	YES				
Head/Neck	YES				
Eyes/Sciera/Pupils	YES				
Gross Hearing	YES				
Nose/Mouth/Throat	YES				
Lymph Glands	YES				
Cardiovascular	YES				
Heart Rate	YES				
Rhythm	YES				
Murmur	ABSENT				
If murmur present	xxxxxxxxxxxxxx	Standing Makes it:	Louder	Softer	No Change
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxxx	Squatting makes it:	Louder	Softer	No Change
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	xxxxxxxxxxxxxx	Valsalva makes it:	Louder	Softer	No Change
Femoral Pulses	YES				
Lungs: Auscultation/Percussion	YES				
Chest Contour	YES				
Skin	YES				
Abdomen (liver, spleen, masses)	YES				
Assessment of physical maturation or Tanner Scale	YES				
Testicular Exam (Males Only)	YES				
Neck/Back/Spine:	YES				
Range of Motion	YES				
Scoliosis	ABSENT				
Upper Extremities: (ROM, Strength, Stability)	YES				
Lower Extremities: (ROM, Strength, Stability	YES				
Neurological: Balance & Coordination	YES				
Hernia	ABSENT				
Evidence of Marfan Syndrome	ABSENT				

6. Have you ever had or do you currently have any of the following *general or exercise related conditions*:
   a. Difficulty breathing? Y / N / Don't Know
      (1) During exercise? Y / N / Don't Know
      (2) After running one mile? Y / N / Don't Know
      (3) Coughing, wheezing or shortness of breath in weather changes? Y / N / Don't Know
      (4) Exercise-induced asthma? Y / N / Don't Know
         (a) Controlled with medication? (specify _____) Y / N / Don't Know
         (b) Experience dizziness, passing out or fainting? Y / N / Don't Know
   b. Viral infections (e.g. mono, hepatitis, coxsackie virus)? Y / N / Don't Know
   c. Become tired more quickly than others? Y / N / Don't Know
   d. Any of the following skin conditions:
      (1) Cold sores/herpes, impetigo, MRSA, ringworm, warts? Y / N / Don't Know
      (2) Sun sensitivity? Y / N / Don't Know
   e. Weight gain/loss (of 10 pounds or more)? Y / N / Don't Know
      (1) Do you want to weigh more or less than you do now? Y / N / Don't Know
   f. Ever had feelings of depression? Y / N / Don't Know
   g. Heat-related problems (dehydration, dizziness, fatigue, headache)? Y / N / Don't Know
      (1) Heat exhaustion (cool, clammy, damp skin)? Y / N / Don't Know
      (2) Heat stroke (hot, red, dry skin)? Y / N / Don't Know
      (3) Muscle cramps? Y / N / Don't Know
   h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? Y / N / Don't Know

   Explain all "yes" answers here (include relevant dates):

   _____

   _____

   _____

7. Females Only:
   Age of onset of menstruation: _____ How many menstrual periods in the last twelve (12) months? _____

   How many periods missed in the last twelve (12) months? _____

8. Males Only:
   Have you had any swelling or pain in your testicles or groin? Y / N / Don't Know

---

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

_____ _____

Signature, Parent/Guardian or Student Age 18 Date of Signature:

THIS COMPLETED AND SIGNED HEALTH HISTORY QUESTIONNAIRE MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.

PLEASE NOTE: IF A STUDENT PARTICIPATES IN A SECOND, THRID, OR FOURTH SPORT DURING A SINGLE SCHOOL YEAR, THIS FORM MUST BE COMPLETED FOR EACH SPORT BUT DOES NOT NEED THE SIGNATURE OF AN EXAMINING PROVIDER.

2. Have you ever had, or do you currently have, any of the following *head-related* conditions:

a. Concussion or head injury (including "bell rung" or a "ding")?	Y / N / Don't Know
b. Memory loss?	Y / N / Don't Know
c. Knocked out?	Y / N / Don't Know
d. A seizure?	Y / N / Don't Know
e. Frequent or severe headaches (with or without exercise)?	Y / N / Don't Know
f. Fuzzy or blurry vision	Y / N / Don't Know
g. Sensitivity to light/noise	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

3. Have you ever had, or do you currently have, any of the following *heart-related* conditions:

a. Restriction from sports for heart problems?	Y / N / Don't Know
b. Chest pain or discomfort?	Y / N / Don't Know
c. Heart murmur?	Y / N / Don't Know
d. High blood pressure?	Y / N / Don't Know
e. Elevated cholesterol level?	Y / N / Don't Know
f. Heart infection?	Y / N / Don't Know
g. Dizziness or passing out during or after exercise without known cause?	Y / N / Don't Know
h. Has a provide ever ordered a heart test (EKG, echocardiogram, stress test, Holter monitor?)	Y / N / Don't Know
i. Racing or skipped heartbeats?	Y / N / Don't Know
j. Unexplained difficulty breathing or fatigue during exercise?	Y / N / Don't Know
k. Any family member (blood relative):	
(1) Under age 50 with a heart condition?	Y / N / Don't Know
(2) With Marfan Syndrome?	Y / N / Don't Know
(3) Died of a heart problem before age 50? If yes at what age? _____	Y / N / Don't Know
(4) Died with no known reason?	Y / N / Don't Know
(5) Died while exercising? If yes, was it during or after? (circle one)	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

4. Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat* conditions:

a. Vision problems?	Y / N / Don't Know
(1) Wear contacts, eyeglasses or protective eye wear? (circle which type)	Y / N / Don't Know
b. Hearing loss or problems?	Y / N / Don't Know
(1) Wear hearing aides or implants?	Y / N / Don't Know
c. Nasal fractures or frequent nose bleeds?	Y / N / Don't Know
d. Wear braces, retainer or protective mouth gear?	Y / N / Don't Know
e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)?	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

5. Have you ever had, or do you currently have, any of the following neuromuscular/orthopedic conditions:

a. Numbness, a "burner", "stinger" or pinched nerve?	Y / N / Don't Know
b. A sprain?	Y / N / Don't Know
c. A strain?	Y / N / Don't Know
d. Swelling or pain in muscles, tendons, bones or joints?	Y / N / Don't Know
e. Dislocated joint(s)?	Y / N / Don't Know
f. Upper or lower back pain?	Y / N / Don't Know
g. Fracture(s) stress fracture(s), or broken bone(s)?	Y / N / Don't Know
h. Do you wear any protective braces or equipment?	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

WW-P REGIONAL SCHOOL DISTRICT HEALTH FORM

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____ Date of Last Sports Physical: _____

Student's Name: _____ Sex: M F (circle one) Age: _____ Grade: _____

Date of Birth: ____/____/____ School: _____

Sport(s): _____ Home Phone: ( )_____

Provider Name (Medical Home):_____ Phone _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name of parent/guardian: _____ Relationship to student: _____

Phone (work): _____ Phone (home): _____ Phone (cell): _____

Additional emergency contact: _____ Relationship to student: _____

Phone (work): _____ Phone (home): _____ Phone (cell): _____

Directions: Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Have you ever had, or do you currently have:
   - a. Restriction from sports for a health related problem? Y / N / Don't Know
   - b. An injury or illness since your last exam? Y / N / Don't Know
   - c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know
     - (1) An inhaler or other prescription medicine to control asthma? Y / N / Don't Know
   - d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know
   - e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
   - f. Any allergies to medications? Y / N / Don't Know
   - g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't Know
     - (1) If yes, check type of reaction:
       - ☐ Rash ☐ Hives ☐ Breathing or other anaphylactic reaction
     - (2) Take any medication/Epipen taken for allergy symptoms? (List below) Y / N / Don't Know
   - h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know
   - i. A blood relative who died before age 50? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

_____

_____

_____

List all medications here:

Name	Dosage	Frequency

WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT

Parent Permission for Administration of Medication in School

Student's Name_____**D.O.B.**_____ **Grade**_____

Administration of medication during school hours **is not** encouraged. However, if a physician determines that failure to take medication would jeopardize the health or school attendance of a student, the medication will be given by the school nurse. In so doing, the West Windsor-Plainsboro Board of Education and its employees shall incur no liability for any benefits or consequences occurring from the administration of the medicine.

I hereby request that the school nurse administer _____ as
Name of Medication

Directed by my physician. I will supply the medication in its original container and personally deliver it to the school nurse.

Medication Information /Adjustments

If this medication is to be given on a regular basis, please indicate what needs to be done if the student is on a class trip or on early closing days. ***Teaching staff can not administer.***

Check One:

_____Student will not be taking the medication when going on a class trip.

_____Administer the medication when the student returns from the class trip.

_____Parent will administer the medication when accompanying student on the trip.

Circle One: Administer/Do Not Administer the medication on early closing days.

When applicable and in accordance with the West Windsor-Plainsboro School District's policy, I give permission for my son/daughter to self-administer the above medication. I also understand that the self-administration privilege shall be revoked if it is deemed that my son/daughter has failed to comply with school policy and tenets of the agreement to self-medicate.

I relieve the West Windsor-Plainsboro Board of Education and its employees of any liability for the benefits or consequences arising from the administration or student self-administration of this medication.

_____ _____

Signature of Parent/Guardian **Date**

_____

Parent/Guardian Name (Print/Type/Stamp)

WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT

Parent Permission for Administration of Medication in School

Student's Name_____ **D.O.B.**_____ **Grade**_____

Administration of medication during school hours is not encouraged. However, if a physician determines that failure to take medication would jeopardize the health or school attendance of a student, the medication will be given by the school nurse. In so doing, the West Windsor-Plainsboro Board of Education and its employees shall incur no liability for any benefits or consequences occurring from the administration of the medicine.

I hereby request that the school nurse administer _____ as
Name of Medication

Directed by my physician. I will supply the medication in its original container and personally deliver it to the school nurse.

Medication Information /Adjustments

If this medication is to be given on a regular basis, please indicate what needs to be done if the student is on a class trip or on early closing days. ***Teaching staff can not administer.***

Check One:

_____Student will not be taking the medication when going on a class trip.

_____Administer the medication when the student returns from the class trip.

_____Parent will administer the medication when accompanying student on the trip.

Circle One: Administer/Do Not Administer the medication on early closing days.

When applicable and in accordance with the West Windsor-Plainsboro School District's policy, I give permission for my son/daughter to self-administer the above medication. I also understand that the self-administration privilege shall be revoked if it is deemed that my son/daughter has failed to comply with school policy and tenets of the agreement to self-medicate.

I relieve the West Windsor-Plainsboro Board of Education and its employees of any liability for the benefits or consequences arising from the administration or student self-administration of this medication.

_____ _____

Signature of Parent/Guardian **Date**

_____

Parent/Guardian Name (Print/Type/Stamp)

WEST WINDSOR-PLAINSBORO REGIONAL SCHOOL DISTRICT

___HSS ___HSN ___Grover MS ___Community MS

___Millstone River ___Village ___ Hawk ___DN

___Wicoff ___ Town Center

Please check one

Prescription Form for Administration of Medication in School

Student's Name_____**D.O.B.**_____ **Grade**_____

Diagnosis _____

Name of Medication _____ **Dosage**_____

Time and Circumstances of Administration_____

Possible side effects:_____

Length of time the prescription is valid _____**(May not exceed the school year)**

When specific guidelines are followed, a student may self-administer medication. Self-administration of a prescribed medication is permitted only in exceptional circumstances when a life threatening condition exists. For purposes of the Board policy life threatening illness is defined as, "*...an illness or condition that requires an immediate response to specific symptoms or sequelae that if left untreated may lead to potential loss of life such as, but not limited to, the use of an inhaler to treat an asthmatic attack or the use of an adrenaline injection to treat a potential anaphylactic reaction.*"

When self-administration of medication is applicable for a life threatening condition and in accordance with West Windsor-Plainsboro School District policy guidelines are as follows:
Grades K-3 – No student will be allowed to self-administer medication without the assistance of a nurse.
Grades 4-5 – A student will be allowed to use inhalers without nurse assistance on field trips only.
Grades 6-12 – A student may self-administer medication for life threatening illnesses.

_____ is capable and has been instructed in the proper method of
Student's name

self administration of _____as directed.
Medication

When an auto-injector is prescribed, please provide the following information:

Is there a documented history of anaphylaxis? Yes_____ No_____

If yes, please provide the signs/symptoms of this child's anaphylactic episode(s)_____

_____ _____ _____

SIGNATURE OF PHYSICIAN/DENTIST **DATE** **PHONE**

_____

PHYSICIAN/DENTIST NAME (PRINT/TYPE/STAMP)