

# New Jersey Department of Education ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

**Part A: HEALTH HISTORY QUESTIONNAIRE**-Completed by the parent and student and reviewed by examining provider  
**Part B: PHYSICAL EVALUATION FORM**-Completed by examining licensed provider with MD, DO, APN or PA

## 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: \_\_\_\_\_ District: \_\_\_\_\_

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 <b>allergies</b> to medications?  | <b>Y / N / Don't Know</b> |
| g. Any allergies to bee stings, pollen, latex or foods?  | Y / N / Don't Know        |
| (1.) If yes, check type of reaction:   |                           |
| <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> 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):

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**List all medications here:**

Medication Name	Dosage	Frequency

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 |
| c. A seizure?   | Y / N / Don't Know |
| d. Frequent or severe headaches (With or without exercise)?       | Y / N / Don't Know |
| e. Fuzzy or blurry vision   | Y / N / Don't Know |
| f. Sensitivity to light/noise                                     | Y / N / Don't Know |

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

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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 provider 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):

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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):

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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):

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6. Have you ever had or do you currently have any of the following *general or exercise related conditions*:

- a. Difficulty breathing?
  - (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
    - i. Controlled with medication? (specify \_\_\_\_\_) Y / N / Don't Know
    - ii. 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):

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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 MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.**

# ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

## Part B: Physical Evaluation Form

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

### -STUDENT INFORMATION-

Student's Name: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
 Sex: M F (circle one) Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 School: \_\_\_\_\_ District: \_\_\_\_\_  
 Parent/Guardian's Full Name: \_\_\_\_\_

### - EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

If conducted by school physician check here

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

### - FINDINGS OF PHYSICAL EVALUATION -

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_ bpm.  
 Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it:   Louder           Softer           No Change
		Squatting makes it:   Louder           Softer           No Change
		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	

Most recent immunizations and dates administered:

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Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Additional observations:

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General Diagnosis:

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General Recommendations:

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

**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                       NON-CONTACT/STRENUOUS  
 LIMITED CONTACT                             NON-CONTACT/NON-STRENUOUS
- Due to: \_\_\_\_\_

**HISTORY REVIEWED AND STUDENT EXAMINED BY:**

**Physician's/Provider's Stamp:**

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

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**

## 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; Heart 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	Shot 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 heart 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

### 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

HCM = Hypertrophic Cardio Myopathy

AS = Aortic Stenosis

AI = Aortic Insufficiency

MR = Mitral Regurgitation

MVP = Mitral Valve Prolapse



**MINIMAL IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY**  
**N.J.A.C. 8:57-4: Immunization of Pupils in School**

DISEASE(S)	MEETS IMMUNIZATION REQUIREMENTS	COMMENTS
<b>DTaP</b>	(AGE 1-6 YEARS): 4 doses, with one dose given on or after the 4th birthday, OR any 5 doses. (AGE 7-9 YEARS): 3 doses of Td or any previously administered combination of DTP, DTaP, and DT to equal 3 doses.	Any child entering pre-school, pre-Kindergarten, or Kindergarten needs a minimum of four doses. Pupils after the seventh birthday should receive adult type Td. DTP/Hib vaccine and DTaP also valid DTP doses. Laboratory evidence of immunity is also acceptable.
<b>Tdap</b>	GRADE 6 (or comparable age level for special education programs): 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. A child does not need a Tdap dose until FIVE years after the last DTP/DTaP or Td dose.
<b>POLIO</b>	(AGE 1-6 YEARS): 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses. (AGE 7 or OLDER): Any 3 doses.	Either Inactivated Polio Vaccine (IPV) or Oral Polio Vaccine (OPV) separately or in combination is acceptable. Polio vaccine is not required of pupils 18 years of age or older. Laboratory evidence of immunity is also acceptable.
<b>MEASLES</b>	If born before 1-1-90, 1 dose of a live Measles-containing vaccine on or after the first birthday. If born on or after 1-1-90, 2 doses of a live Measles-containing vaccine on or after the first birthday. If entering a college or university after 9-1-95 and previously unvaccinated, 2 doses of a live Measles-containing vaccine on or after the first birthday.	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs a minimum of 1 dose of measles vaccine. Any child entering Kindergarten needs 2 doses. Previously unvaccinated students entering college after 9-1-95 need 2 doses of measles-containing vaccine or any combination containing live measles virus administered after 1968. Documentation of 2 prior doses is acceptable. Laboratory evidence of immunity is also acceptable. Intervals between first and second measles/MMR/MR doses cannot be less than 1 month.
<b>RUBELLA and MUMPS</b>	1 dose of live Mumps-containing vaccine on or after the first birthday. 1 dose of live Rubella-containing vaccine on or after the first birthday.	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs 1 dose of rubella and mumps vaccine. Each student entering college for the first time after 9-1-95 needs 1 dose of rubella and mumps vaccine or any combination containing live rubella and mumps virus administered after 1968. Laboratory evidence of immunity is also acceptable.
<b>VARICELLA</b>	1 dose on or after the first birthday.	All children 19 months of age and older enrolled into a child care/pre-school center after 9-1-04 or children born on or after 1-1-98 entering a school for the first time in Kindergarten or Grade 1 need 1 dose of varicella vaccine. Laboratory evidence of immunity, physician's statement or a parental statement of previous varicella disease is also acceptable.
<b>HAEMOPHILUS INFLUENZAE B (Hib)</b>	(AGE 2-11 MONTHS) <sup>(1)</sup> : 2 doses (AGE 12-59 MONTHS) <sup>(2)</sup> : 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten. (1) Minimum of 2 doses of Hib vaccine is needed if between the ages of 2-11 months. (2) Minimum of 1 dose of Hib vaccine is needed after the first birthday. DTP/Hib and Hib/Hep B also valid Hib doses.
<b>HEPATITIS B</b>	(K-GRADE 12): 3 doses or 2 doses <sup>(1)</sup>	(1) If a child is between 11-15 years of age and has not received 3 prior doses of Hepatitis B then the child is eligible to receive 2-dose Hepatitis B Adolescent formulation. Laboratory evidence of immunity is also acceptable.
<b>PNEUMO-COCCAL</b>	(AGE 2-11 MONTHS) <sup>(1)</sup> : 2 doses (AGE 12-59 MONTHS) <sup>(2)</sup> : 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten. (1) Minimum of 2 doses of Pneumococcal vaccine is needed if between the ages of 2-11 months. (2) Minimum of 1 dose of Pneumococcal vaccine is needed after the first birthday.
<b>MENINGO-COCCAL</b>	(Entering GRADE 6 (or comparable age level for Special Ed programs): 1 dose <sup>(1)</sup> (Entering a four-year college or University, previously unvaccinated and residing in a campus dormitory): 1 dose <sup>(2)</sup>	(1) For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. (2) Previously unvaccinated students entering a four-year college or university after 9-1-04 and who reside in a campus dormitory, need 1 dose of meningococcal vaccine. Documentation of one prior dose is acceptable.
<b>INFLUENZA</b>	(AGES 6-59 MONTHS): 1 dose ANNUALLY	For children enrolled in child care, pre-school or pre-Kindergarten on or after 9-1-08. 1 dose to be given between September 1 and December 31 of each year.

**AGE APPROPRIATE VACCINATIONS (FOR LICENSED CHILD CARE CENTERS/PRE-SCHOOLS)**

**CHILD'S AGE**

2-3 Months  
4-5 Months  
6-7 Months  
8-11 Months  
12-14 Months  
15-17 Months  
18 Months-4 Years

**NUMBER OF DOSES CHILD SHOULD HAVE (BY AGE):**

1 dose DTaP, 1 dose Polio, 1 dose Hib, 1 dose PCV7  
2 doses DTaP, 2 doses Polio, 2 doses Hib, 2 doses PCV7  
3 doses DTaP, 2 doses Polio, 2-3 doses Hib, 2-3 doses PCV7, 1 dose Influenza  
3 doses DTaP, 2 doses Polio, 2-3 doses Hib, 2-3 doses PCV7, 1 dose Influenza  
3 doses DTaP, 2 doses Polio, 1 dose Hib, 2-3 doses PCV7, 1 dose Influenza  
3 doses DTaP, 2 doses Polio, 1 dose MMR, 1 dose Hib, 1 dose PCV7, 1 dose Influenza  
4 doses DTaP, 3 doses Polio, 1 dose MMR, 1 dose Hib, 1 dose Varicella, 1 dose PCV7, 1 dose Influenza

**PROVISIONAL ADMISSION:**

Provisional admission allows a child to enter/attend school but must have a minimum of one dose of each of the required vaccines. Pupils must be actively in the process of completing the series. If a pupil is <5 years of age, they have 17 months to complete the immunization requirements. If a pupil is 5 years of age and older, they have 12 months to complete the immunization requirements.

**GRACE PERIODS:**

- 4-day grace period: All vaccines doses administered less than or equal to four days before either the specified minimum age or dose spacing interval shall be counted as valid and shall not require revaccination in order to enter or remain in a school, pre-school or child care facility.
- 30-day grace period: Those children transferring into a New Jersey school, pre-school, or child care center from out of state/out of country may be allowed a 30-day grace period in order to obtain past immunization documentation before provisional status shall begin.

**COUNTRIES WITH AN INCIDENCE OF TB INSUFFICIENT TO REQUIRE MANTOUX  
TUBERCULIN SKIN TESTING AS A REQUIREMENT FOR SCHOOL ENTRY IN NEW JERSEY**

Antigua and Barbuda  
Australia  
Austria  
Barbados  
Belgium  
Bermuda  
Canada  
Cayman Islands  
Cuba  
Cyprus  
Czech Republic  
Denmark  
Finland  
France  
Germany  
Greenland  
Grenada  
Iceland  
Ireland  
Israel  
Italy

Jamaica  
Jordan  
Lebanon  
Luxembourg  
Malta  
Monaco  
Montserrat  
Netherlands  
Netherlands Antilles  
New Zealand  
Norway  
Oman  
Puerto Rico  
Saint Kitts and Nevis  
San Marino  
Sweden  
Switzerland  
Trinidad and Tobago  
United Kingdom of Great Britain and Northern Ireland  
United States of America  
United States Virgin Islands

**Students entering a U.S. school for the first time in New Jersey or transferring into a New Jersey school from ANY country NOT listed above must be Mantoux tuberculin skin tested unless they meet an exemption criterion listed on page 1, Section II. 1 or Section II. 2.**