New Jersey Department of Education
ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM
Part A: HEALTH HISTORY QUESTIONNAIRE
(To be completed by the parent and student)
(Pursuant to N.J.A.C. 6A:16 Programs to Support Student Development)

Today’s Date: __________________ Date of Last Physical: ______________________

Student’s Name:______________________ Sex: M  F (circle one)  Age: ______

Date of Birth: _______________________  Sport: ____________________  Home Phone: _____________________________

Grade: __________  School: _____________________________  District: _________________________

Physician: ___________________________  Phone: __________________________  Fax: ____________________

EMERGENCY CONTACT INFORMATION
Name: ____________________________  Relationship to student: _______________________

Phone (work): _____________________  Phone (home):______________________________  Phone (cell): ______________

Directions: Please answer the following questions about the student’s medical history. Explain all “yes” responses at the bottom of the page. Please respond to all questions.

1. Have you had or do you currently have:
   a. A sports physical within the past 365 days? 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)?
      1. Use 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?
      1. Type of reaction: Rash? Hives? Other skin condition? (Circle all that apply.) Y / N / Don’t Know
      2. Take any medication/Epipen taken for allergy symptoms? (List below.) Y / N / Don’t Know
   h. Any anemias or blood disorders? Y / N / Don’t Know

2. Have you had or do you currently have any of the following head-related conditions since your last physical:
   a. Concussion requiring a physician’s evaluation? Y / N / Don’t Know
      1. How often and when? (Answer below.)
   b. Memory loss or been knocked out? Y / N / Don’t Know
   c. A seizure? Y / N / Don’t Know
   d. Frequent or severe headaches? Y / N / Don’t Know

3. Have you had or do you currently have any of the following heart-related conditions since your last physical:
   a. Chest pain? Y / N / Don’t Know
   b. Heart murmur? Y / N / Don’t Know
   c. High blood pressure or elevated cholesterol level? Y / N / Don’t Know
   d. Restriction from sports for heart problems? Y / N / Don’t Know
   e. Any family member or relative:
      1. Die of a heart problem before age 35? Y / N / Don’t Know
      2. Die of a heart problem before age 50? Y / N / Don’t Know
      3. Die with no known reason? Y / N / Don’t Know
      4. Die while exercising? During or after? (Circle one.) Y / N / Don’t Know
      5. With Marfan’s Syndrome? Y / N / Don’t Know

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4. Have you had or do you currently have any of the following eye, ear, nose, mouth or throat conditions since your last physical:
   a. Vision problems?
      1. Wear contacts, eyeglasses or protective eye wear? (Circle which type.)
   b. Hearing loss or problems?
      1. Wear hearing aides or implants?
   c. Nasal fractures or frequent nose bleeds?
   d. Wear braces, retainer or protective mouth gear?
   e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)?

5. Have you had or do you currently have any of the following neuromuscular/orthopedic conditions since your last physical:
   a. A burner, stinger or pinched nerve?
   b. A sprain?
   c. A strain?
   d. Swelling or pain in muscles, tendons, bones or joints?
   e. A dislocated joint(s)?
   f. Upper or lower back pain?
   g. Fracture(s) or stress fracture(s)?
   h. Do you wear any protective braces or equipment for any prior injury?

6. Have you had or do you currently have any of the following general or exercise related conditions since your last physical:
   a. Difficulty breathing? During Exercise? (Circle one.)
      1. After running one mile
      2. Coughing, wheezing or shortness of breathe in weather changes?
      3. Exercise-induced asthma
         i. Controlled with medication? (List below.)
         ii. Experience dizziness, passing out or fainting?
   b. Viral infections (e.g. mono, hepatitis)?
   c. Become tired more quickly than your friends?
   d. Any of the following skin conditions:
      1. Acne, contact dermatitis, ringworm, warts, herpes?
      2. Sun sensitivity?
   e. Weight gain/loss (greater than or less than 10 pounds)?
      1. Do you want to weigh more or less than you do now?
   f. Ever had feelings of depression?
   g. Heat-related problems (dehydration, dizziness, fatigue, headache)?
      1. Heat exhaustion (cool, clammy, damp skin)?
      2. Heat stroke (hot, red, dry skin)?

7. Females only:
   Age of onset of menstruation: _____________________________________________
   Date of last menstruation: _______________________________________________
   Most number of days between menstruation cycle(s): ________________________

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

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

Parent/Guardian Signature: ___________________________  Date: ________________
ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM
Part B: Physical Examination
(To be completed by the examining physician)

Examination Date:

-STUDENT INFORMATION-
Student’s Name: __________________________________ Sport: _______________________________________________________
Sex: M  F  (circle one) Age: ________ Grade: ___________ Date of Birth: _________________________________________
Address: _____________________________________________________________________________________________________________
City/State/Zip: ___________________________________________ Home Phone: _________________________________________
School: _____________________________________________________ District: _____________________________________________
Parent/Guardian’s Full Name: ____________________________________________________________________________________________

-PHYSICIAN INFORMATION-
Name: _______________________________ Phone: __________________________ Fax: _____________________
Address: ______________________________ City/State/Zip:____________________________________________________
__________________________________________________________________________________________________________

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH PAGES

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Normal? (Circle One)</th>
<th>Abnormal Findings/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head/Neck</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Eyes/Sclera/Pupils</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Ears</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Nose/Mouth/Throat</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Heart: Murmurs/Rhythms</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Lungs: Auscultation/Percussion</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Chest Contour</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Skin</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Abdomen: Assessment (incl. liver, spleen)</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Tanner Stage:</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Testes/Onset of Menses</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Neck/Back/Spine:</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Range of Motion:</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Scoliosis:</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Upper Extremities:</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Lower Extremities:</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>Neurological:</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>Balance &amp; Coordination:</td>
<td>YES</td>
<td>NO</td>
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<tr>
<td>Romberg:</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Heel Walk:</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Tandem Walk:</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Nose Touch:</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Toe Walk:</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Hernia? (if yes/possible, please explain)</td>
<td>YES/ Possible</td>
<td>NO</td>
</tr>
</tbody>
</table>

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Most recent immunizations/Dates:

Medications currently being used:

Additional Observations:

General Diagnosis: ____________________________________________________________________________

Recommendations: _____________________________________________________________________________

**CLEARANCES**

A. **Student MAY participate in the following sports:** (CHECK ALL THAT APPLY)

<table>
<thead>
<tr>
<th>Contact/Collision</th>
<th>Limited Contact</th>
<th>Strenuous</th>
<th>Non-Contact</th>
<th>Non-strenuous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Hockey</td>
<td>Baseball</td>
<td>Discus</td>
<td>Bowling</td>
<td></td>
</tr>
<tr>
<td>Football</td>
<td>Basketball</td>
<td>Javelin</td>
<td>Golf</td>
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<tr>
<td>Ice Hockey</td>
<td>Cheerleading</td>
<td>Shot put</td>
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</tr>
<tr>
<td>Lacrosse</td>
<td>Diving</td>
<td>Rowing</td>
<td></td>
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<tr>
<td>Soccer</td>
<td>Fencing</td>
<td>Running/Cross Country</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrestling</td>
<td>Field</td>
<td>Strength Training</td>
<td></td>
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<tr>
<td></td>
<td>High Jump</td>
<td>Swimming</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Pole vault</td>
<td>Tennis</td>
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<tr>
<td></td>
<td>Gymnastics</td>
<td>Track</td>
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<tr>
<td></td>
<td>Skiing</td>
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<tr>
<td></td>
<td>Softball</td>
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<tr>
<td></td>
<td>Volleyball</td>
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</tbody>
</table>

B. **Student MAY participate in following sport(s) ONLY AFTER completing evaluation/rehabilitation:** (CHECK ALL THE APPLY)

<table>
<thead>
<tr>
<th>Contact/Collision</th>
<th>Limited Contact</th>
<th>Non-Contact</th>
<th>Non-strenuous</th>
</tr>
</thead>
</table>

Please specify each condition requiring clearance before participating in a sport in the classification checked above:
________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________

Conditions requiring clearance before sports participation include, but are not limited to: 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; 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.

**Physician’s/Provider’s Stamp:**

EXAMINED BY:
Family Physician/Provider_____
School Physician_____

____MD ____DO ____NP ____PA

Physician’s/Provider’s Signature: ___________________________ Date: _________________

**NOTE TO SCHOOL PHYSICIANS:** Pursuant to N.J.A.C. 6A:16-2.2, the school physician shall provide written notification to the parent/legal guardian stating approval or disapproval of the student’s participation in athletics based on this medical report. Please attach this form to the notification letter and ensure that this report is made part of the student’s permanent health record.