

# John Witherspoon Middle School

217Walnut Lane, Princeton, New Jersey 08540 t 609.806.4270

It is the practice of the Princeton Public Schools to require a current physical examination for all sixth grade students. In addition, all new students to the district and all athletes must submit a Physical Evaluation Form completed within the past 365 days.

If you want to participate in a sport at JWMS, you should complete:

- 1. The New Jersey Department of Education: PREPARTICIPATION PHYSICAL EVALUATION History form, Physical Examination form and Clearance form
- 2. Athletic Information Form
- 3. Athletic Parental Consent Forms: Review Sudden Cardiac Death pamphlet, NJSIAA Concussion fact sheet, NJSIAA Steroid Testing Policy, NJSIAA Banned drug list, and the Media consent

\*\*\* Please note: Princeton Public Schools in accordance with The State of New Jersey will require all sports physicals to be conducted by physicians who have completed the CARDIAC ASSESSMENT PROFESSIONAL DEVELOPMENT MODULE which is available online to all licensed physicians. The physician must sign the bottom of the physical form stating that they have completed the module. If your child's doctor has not completed this assessment, the physical will not be accepted.

For subsequent sport seasons, during the same school year, simply complete:

- 1. Athletic Information Form
- 2. Health History Update
- 3. Athletic Parental Consent Forms

Please keep us informed of any health related conditions that may affect your child and if he/she is taking daily medication even if it is not during school hours. If your son/daughter needs to take any medication during school hours or for emergency use (asthma or anaphylaxis) have the pediatrician complete the appropriate forms. These can be obtained on the PPS website <a href="www.princetonk12.org">www.princetonk12.org</a> or from the school's health office.

Please update the health office with all emergency contact information.

All completed forms must be submitted to the school nurse **within 90 days** of the start of each sport season. Please adhere to posted sport forms date deadlines. Be advised that submitting the forms within the last 15 days before the start of the sport season may result in your child not being eligible to start the season on time because once forms are received they must be sent to our school doctor and processed for approval.

Thank you for your cooperation.

JWMS School Nurse

Kathleen Bihuniak RN, MSN, CSN

kathleen\_bihuniak@princetonk12.org Phone (609) 806-4273 Fax (609) 806-4271



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## Athletic Forms Checklist

# 1. Physical Evaluation Form (History, Physical, Clearance)

a.	Histo	ory Form
	i.	All 54 questions answered
	ii.	All Yes answers explained in detail
	iii.	Student signature
	iv.	Parent Signature
b.	Phys	ical Form
	i.	Completed by MD
	ii.	Height, Weight, Vision, B/P filled in
	iii.	Date of PE clearly indicated
	iv.	Physician signature and stamp
	v.	Date of physician's signature (may be different than date of PE)
c.	Clea	rance Form
	i.	Completed by MD
	ii.	Signed, dated and stamped by MD
	iii.	MD signature on the Cardiac Assessment Professional Development module line

2. Athletic Akcnowledgement and Consent Form – reviewed and signed by both student and parent

## Policies can be found on website

- i. Sudden Cardiac Death Brochure
- ii. NJSIAA Concussion Policy Acknowledgement
- iii. NJSIAA Steroid Testing Policy
- iv. Media Coverage Consent
- **3. Are Immunizations up to date** Must have Tdap and Menactra by age 11.



# **HEALTH HISTORY UPDATE QUESTIONNAIRE**

Student		Age	Grade
	ninationSport		
	tion physical examination, has your son/daughter:		
	d not to participate in a sport?		_ No
	a, been unconscious or lost memory from a blow to the head?		
_	ned/strained/dislocated any muscle or joints?		No
4. Fainted or "blacked ou If yes, was this during	t?" or immediately after exercise?		_ No
•	ns, shortness of breath or "racing heart?"	Yes	No
6. Has there been a recen	t history of fatigue and unusual tiredness?	Yes	No
-	ad to go to the emergency room?		_ No
	examination, has there been a sudden death in the family or attack or "heart trouble?"	•	nember of the fam
* *	ng any over-the-counter or prescribed medications? tion(s)		_ No

**ATTENTION PARENT/GUARDIAN:** The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

#### ■ PREPARTICIPATION PHYSICAL EVALUATION

### **HISTORY FORM**

Name				Date of birth		
Sex Age	Grade Sc	School Sport(s)				
Medicines and Allergies: Pl	ease list all of the prescription and over	r-the-co	unter m	nedicines and supplements (herbal and nutritional) that you are currently	taking	
				,		
Do you have any allergies?  ☐ Medicines	☐ Yes ☐ No If yes, please id ☐ Pollens	entity spe	ecific all	lergy below. □ Food □ Stinging Insects		
Evnlain "Voe" anewere helow	Circle questions you don't know the a	neware t	·n			
GENERAL QUESTIONS	circle questions you don't know the a	Yes	No	MEDICAL QUESTIONS	Yes	No
	estricted your participation in sports for	163	NU	26. Do you cough, wheeze, or have difficulty breathing during or	100	110
any reason?				after exercise?		_
	dical conditions? If so, please identify emia □ Diabetes □ Infections			27. Have you ever used an inhaler or taken asthma medicine?  28. Is there anyone in your family who has asthma?		-
Other:				29. Were you born without or are you missing a kidney, an eye, a testicle		$\vdash$
3. Have you ever spent the nigh	t in the hospital?			(males), your spleen, or any other organ?		<u> </u>
4. Have you ever had surgery?				30. Do you have groin pain or a painful bulge or hernia in the groin area?		<u> </u>
5. Have you ever passed out or		Yes	No	31. Have you have any replace processes (mono) within the last month?		$\vdash$
AFTER exercise?	nearly passed out Doning of			32. Do you have any rashes, pressure sores, or other skin problems?  33. Have you had a herpes or MRSA skin infection?		+
	t, pain, tightness, or pressure in your			34. Have you ever had a head injury or concussion?		
chest during exercise?	-1:- h - 4- (:			35. Have you ever had a hit or blow to the head that caused confusion,		
	skip beats (irregular beats) during exercise? at you have any heart problems? If so,	-		prolonged headache, or memory problems?		<u> </u>
check all that apply:	at you have any neart problems: it so,			36. Do you have a history of seizure disorder?		₩
High blood pressure	☐ A heart murmur			37. Do you have headaches with exercise?		-
☐ High cholesterol☐ Kawasaki disease	☐ A heart infection Other:			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
	rest for your heart? (For example, ECG/EKG,			39. Have you ever been unable to move your arms or legs after being hit or falling?		
	el more short of breath than expected			40. Have you ever become ill while exercising in the heat?		<u> </u>
during exercise?	oined column?			41. Do you get frequent muscle cramps when exercising?		₩
11. Have you ever had an unexpl	t of breath more quickly than your friends			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?		┼
during exercise?	to broad more quickly than your monde			44. Have you had any eye injuries?		$\vdash$
HEART HEALTH QUESTIONS AB	OUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?		<del>                                     </del>
	lative died of heart problems or had an udden death before age 50 (including			46. Do you wear protective eyewear, such as goggles or a face shield?		
	ccident, or sudden infant death syndrome)?			47. Do you worry about your weight?		
	ave hypertrophic cardiomyopathy, Marfan			48. Are you trying to or has anyone recommended that you gain or		
, , , , ,	ght ventricular cardiomyopathy, long QT e, Brugada syndrome, or catecholaminergic			lose weight?  49. Are you on a special diet or do you avoid certain types of foods?		1
polymorphic ventricular tachy	/cardia?			50. Have you ever had an eating disorder?		<del>                                     </del>
15. Does anyone in your family h implanted defibrillator?	ave a heart problem, pacemaker, or			51. Do you have any concerns that you would like to discuss with a doctor?		t
•	d unexplained fainting, unexplained			FEMALES ONLY		
seizures, or near drowning?	,			52. Have you ever had a menstrual period?		
BONE AND JOINT QUESTIONS		Yes	No	53. How old were you when you had your first menstrual period?		
<ol> <li>Have you ever had an injury t that caused you to miss a pra</li> </ol>	to a bone, muscle, ligament, or tendon actice or a game?			54. How many periods have you had in the last 12 months?		
	n or fractured bones or dislocated joints?			Explain "yes" answers here		
	that required x-rays, MRI, CT scan,					
20. Have you ever had a stress fr						
	you have or have you had an x-ray for neck ability? (Down syndrome or dwarfism)					
-	orthotics, or other assistive device?	1				
23. Do you have a bone, muscle,	· · · · · · · · · · · · · · · · · · ·					
24. Do any of your joints become	painful, swollen, feel warm, or look red?					
25. Do you have any history of ju	venile arthritis or connective tissue disease	)				

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### ■ PREPARTICIPATION PHYSICAL EVALUATION

# THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam						
Name			Date of birth			
Sav Ana	Grade	School				
Sex Age	uraue	301001	Sport(s)			
1. Type of disability						
2. Date of disability						
3. Classification (if avail	lable)					
4. Cause of disability (b	irth, disease, accident/trauma, other)					
5. List the sports you ar	re interested in playing					
				Yes	No	
6. Do you regularly use	a brace, assistive device, or prostheti	0?				
7. Do you use any spec	ial brace or assistive device for sports	?				
8. Do you have any rash	hes, pressure sores, or any other skin	problems?				
	ng loss? Do you use a hearing aid?					
10. Do you have a visual						
	ial devices for bowel or bladder functi	on?				
	or discomfort when urinating?					
13. Have you had autono						
		nermia) or cold-related (hypothermia) illnes	ss?			
15. Do you have muscle						
16. Do you have frequen	t seizures that cannot be controlled by	medication?				
Explain "yes" answers h	ere					
Please indicate if you ha	ve ever had any of the following.					
				Yes	No	
Atlantoaxial instability						
X-ray evaluation for atlan	toaxial instability					
Dislocated joints (more th	nan one)					
Easy bleeding						
Enlarged spleen						
Hepatitis						
Osteopenia or osteoporos	sis					
Difficulty controlling bow	el					
Difficulty controlling blad						
Numbness or tingling in a						
Numbness or tingling in I	<u> </u>					
Weakness in arms or han	nds					
Weakness in legs or feet						
Recent change in coordin						
Recent change in ability t	to walk					
Spina bifida						
Latex allergy						
Explain "yes" answers h	ere					
I hereby state that, to the	e best of my knowledge, my answer	rs to the above questions are complete a	and correct.			
Signature of athlete		Signature of parent/guardian		Date		

**NOTE:** The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

### ■ PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name	Date of birth						
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    United by Control of the Control of	☐ Female						
Height Weight		LOOV Commented TO V TO N					
BP / ( / ) Pulse Vision	1	L 20/ Corrected  Y N					
MEDICAL  Appearance  Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)  Eyes/ears/nose/throat	NORMAL	ABNORMAL FINDINGS					
Pupils equal     Hearing							
Lymph nodes							
Heart a     Murmurs (auscultation standing, supine, +/- Valsalva)     Location of point of maximal impulse (PMI)							
Pulses • Simultaneous femoral and radial pulses							
Lungs Abdomen							
Genitourinary (males only) <sup>b</sup>							
Skin  HSV, lesions suggestive of MRSA, tinea corporis							
Neurologic °							
MUSCULOSKELETAL							
Neck Back							
Shoulder/arm							
Elbow/forearm							
Wrist/hand/fingers							
Hip/thigh							
Knee							
Leg/ankle							
Foot/toes							
Functional  Duck-walk, single leg hop							
Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  Consider GU exam if in private setting. Having third party present is recommended.  Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.  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	□ For certain sports						
Reason							
Recommendations							
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, 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 of exam							
Address		Phone					

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Signature of physician, APN, PA \_

#### ■ PREPARTICIPATION PHYSICAL EVALUATION

## **CLEARANCE 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 eva	aluation or treatment for
□ Not cleared	
☐ Pending further evaluation	
☐ For any sports	
☐ For certain sports	
Reason	
Recommendations	
EMERGENCY INFORMATION	
Allergies	
Other information	
HCP OFFICE STAMP	SCHOOL PHYSICIAN:
The office of a minimum and a	
	Reviewed on(Date)
	Approved Not Approved
	Signature:
	articipation physical evaluation. The athlete does not present apparent 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 parer	nts. If conditions arise after the athlete has been cleared for participation,
the physician may rescind the clearance until the problem is resolv (and parents/guardians).	red and the potential consequences are completely explained to the athle
Name of physician, advanced practice nurse (APN), physician assistant (PA	) Date
	Phone
Signature of physician, APN, PA	
Completed Cardiac Assessment Professional Development Module	
DateSignature	
•	

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

# PRINCETON PUBLIC SCHOOLS Princeton, New Jersey 08540

Princeton High School 609-806-4280 John Witherspoon Middle School 609-806-4270

### **ATHLETIC INFORMATION**

Name		Date			
Address		Grade			
		Sport			
Home Phone		Gender Male Female			
Date of Birth		Place of Birth			
Date of entrance into 9 <sup>th</sup> grade					
School attended last year					
Parent/Guardian to be contact in an em	ergency:				
Name		Home Phone			
Cellular Phone	Work Phone_				
Other Emergency Contact: Name		Home Phone			
Cellular Phone	Work Phone_				
	PERMISSION FO	DR ATHLETICS			
To the Principal:					
I hereby give		(student's name) permission to compete in			
		t), sponsored by the Board of Education and under the an activity involves the potential for injury that is			
		proper coaching, use of protective equipment, and			
		ccasion, these injuries can be so severe as to result in			
total disability, paralysis, or even death.	i/we acknowled	ge that I/we have read and understand this warning.			
		Signature of Parent/Guardian			
		Signature of Farent/Odardian			
PERMIS	SION FOR EME	RGENCY TREATMENT			
I hereby give permission for the school can be reached.	to arrange emerg	ency treatment for my child if none of the above adults			
		Signature of Parent/Guardian			
*For emergency situations: Please list below, for the athletic department, any known allergies, medical conditions, pertinent medical diagnosis (acute or chronic) and current medications.					
STATEMENT OF INSURANCE					
My son/daughter is covered for injury under a policy with:					
, , ,	, ,				
Name of Insurance Company		Policy Number			
DO NOT COMPLETE FORM BELOW LINE					
☐ Physical Examination ☐ Parel Other	ntal Permission	□ Academic Eligibility □ Athletic Equipment			

## **Athletic Acknowledgement & Consent Form**

#### N.J.S.I.A.A. CONCUSSION POLICY ACKNOWLEDGEMNT FORM

We have received and reviewed the N.J.S.I.A.A. concussion policy acknowledges, signs and symptoms of a concussion, as well as the basic guidelines protocol.	
Student's Signature:	Date:
Parent's Signature:	Date:
NJSIAA STEROID TESTING POLICY	
We have received and reviewed the N.J.S.I.A.A. steroid testing policy, as We consent to random testing in accordance with the NJSIAA steroid testis student or student's team qualities for a state championship tournament or student may be subject to testing for banned substances.	ing policy. We understand that, if the
Student's Signature:	Date:
Parent's Signature:	Date:
SUDDEN CARDIAC DEATH BROCHURE	
We have received and reviewed the sudden cardiac death in young athletes facts of sudden cardiac death in young athletes. We are also aware of addisubject from the American Heart Association ( <a href="www.heart.org">www.heart.org</a> ) and the Hy ( <a href="www.4hcm.org">www.4hcm.org</a> )	itional resources available on this
Student's Signature:	Date:
Parent's Signature:	Date:
MEDIA COVERAGE	
I hereby give permission for the release of videotapes, audio recordings, as child by name, to the school district and the media for the use in various mews stories, websites and social media outlets, as it pertains to my child a Athletics. I also grant permission for my child to be interviewed by the school Princeton Public Schools District athletics.	nedia outlets including but not limited to and Princeton Public School District
Student's Signature:	Date:
Parent's Signature:	Date:

All of these policies and brochures can be found on the middle school website @ jw.princetonk12.org under athletic – forms.