SPORTS REGISTRATION AND PERMISSION FORM

Student Name: ___________________________ Date: ___________________________

Student ID# ___________________________ School (As of Sept. 2018) ___________________________

Grade (As of Sept. 2018) 6 7 8 9 10 11 12 (Circle One)

Sports: Fall ___________________________ Winter ___________________________ Spring ___________________________

Emergency Contact Information

1. Name: ___________________________ Home Phone# ___________________________ Cell # ___________________________

2. Name: ___________________________ Home Phone# ___________________________ Cell # ___________________________

Part I-Parental Approval Form (to be completed and signed by parent/Guardian)

I/we the undersigned, give my permission for ___________________________ to participate in the sports listed above.

I/we understand that in case of injury to my child, that I am to use my personal medical insurance first, and then will submit any bills in excess of payment by my insurance company to the school district insurance company.

Realizing that such activity involves the potential for injury which is inherent in all sports, I/we acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observation of the rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis or even death. I/we acknowledge that I/we have read and understand this warning.

I hereby confirm my son/daughter lives within the boundaries established by our school district.

Signature ___________________________
Parent/Guardian ___________________________

Part II-Student Participant Form (to be completed and signed by student athlete)

I ___________________________, a student in the Elizabeth Public

Schools, hereby request permission to try out for ___________________________.

Realizing that such activity involves the potential for injury which is inherent in all sports, I/we acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observation of the rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis or even death. I/we acknowledge that I/we have read and understand this warning.

I further promise to abide by all the rules and regulations set forth by the coach. All equipment that was issued to me will be turned in at the end of the season or upon my leaving the squad, and I will make full payment immediately to the Director of Athletics for any missing equipment.

Signature: ___________________________
Student Athlete ___________________________
JUNTA DE EDUCACION DE ELIZABETH
PERMISO PARA DEPORTE ESCOLAR

la parte I-forma de aprobación Paternal (para ser completado y firmado por padre)
Nombre de Estudiante _____________________________ Fecha __________
Identificación Estudiante __________________________ Escuela __________

Grado (Apartir de Sept de 2018) 6 7 8 9 10 11 12 (Marca Uno)

Deporte: otoño __________________ invierno __________________ primavera __________

Contacto de emergencia

1. Nombre: ______________________ Teléfono __________ Celular __________
2. Nombre: ______________________ Teléfono __________ Celular __________

Doy/damos permiso a ____________________________ para su participación en deporte durante la temporada de ____________________________.

Entiendo/entendemos que en caso de lesión a mi hijo/hija primeramente será utilizado mi seguro médico personal. Luego, cuentas recibidas en exceso al pago hecho por mi/nuestro seguro médico serán sometidas a la compañía de seguros del distrito escolar.

Entiendo/entendemos que en estas actividades corren riesgos de lesiones aun bajo dirección y supervisión del director atlético, el uso de equipo avanzado, y observación de los reglamentos del deporte. En ocasiones raras, estas lesiones pueden causar desabilidad permanente, parálisis, o muerte.

Con Mi/nuestra firma, doy/damos conocimiento que he/hemos leído y entiendo/entendemos

Firma de Padre/Guardiante: ____________________________

la parte II-forma de participante de estudiante (para ser completado y firmado por atleta de estudiante)

Yo, __________________________________________, estudiante del Sistema Escolar de Elizabeth, pido permiso para hacer prueba al deporte de ____________________________.

Entiendo que en estas actividades corren riesgos de posible lesiones aun bajo dirección y supervisión del director atlético, el uso de equipo avanzado, y observación de los reglamentos del deporte. En ocasiones raras, estas lesiones pueden causar desabilidad permanente, parálisis, o muerte.

Prometo respetar todas las normas y reglamentos impuestos por el director atlético. Todo equipo que sea entregado a mi persona será inmediatamente devuelto a final de la temporada del deporte, en caso de mi decisión de no continuar participando, o en caso de ser despedido del equipo. Pago inmediato será hecho a director atlético en recompensa de cualquier equipo no devuelto o desaparecido.

Firma de atleta de estudiante: ____________________________
Physical Examination Requirements for Sports Participation

Dear Parents/Guardians:
According to state law and district policy. Students participating in sports must adhere to certain requirements. The following information lists those requirements.

Students who wish to try out for a school athletic squad or team must return a completed district physical Examination Report that includes a review and examination of all body systems. According to state law, "Each student medical examination shall be conducted at the medical home of the student (family physician) and a full report sent to the school" (N.J.A.C.6A: 16-2.2) In other words, your family physician or healthcare provider must complete his or her physical examination. In addition, a Health History Questionnaire must be completed by the parent/guardian prior to each sport's first practice.

It is the responsibility of each student athlete to submit a full report of the examination documented on an approved school district form, dated and signed by your medical provider to the school nurse prior to the start of athletics. The physical examination must have been performed during the academic school year and the health history must be updated/completed within 60 days of the first practice.

The medical history questionnaire must be completed by a parent/guardian not by a student athlete. After you have completed the questionnaire, it should be taken to your family physician or healthcare provider to complete the medical examination.

All completed MIDDLE SCHOOL physical examination forms should be returned to the school nurse in your building. All completed HIGH SCHOOL forms should be returned to the Head Coach, Athletic Trainers, or the Athletic Office. ANY INCOMPLETE FORMS WILL NOT BE ACCEPTED, AND WILL BE RETURNED TO YOU.

After the forms have been checked for accuracy, they will be presented to our Board Physician. He/She will review and then either approve or disapprove the student athlete's participation in athletics.

Parents/guardians will be notified of their child's eligibility to participate via their coach/nurse.

*Please note that the student athlete will not participate in any athletic program until this ENTIRE PROCESS HAS BEEN COMPLETED.
Requisitos de Examen Fisico Para Participacion en Deportes Escolares

Estimados Padres/Guardianes:

De acuerdo con las leyes estatales y las polizas del distrito, todo estudiante participando en deportes los escolares debe cumplir con ciertos requisitos. La siguiente informacion los detalla:

Estudiantes deseano participar en equipos atléticos escolares deben devolver el cuestionario del distrito detallado Reporte de Examen Fisico, el cual incluye un revision completa y una medico de todos los sistemas de cuerpo. De acuerdo con las leyes estatales, “Cada revision y examen medico debe ser conducido en la oficina de su medico de familia y el reporte enviado al colegio.”

(N.J.A.C.6A:16.2.2) En otras palabras, su medico de familia debe administrar el examen fisico.

El cuestionario de la Historia Medica debe ser completado por el padre/guardiante antes de la primera practica de cada deporte en el cual el estudiante desea participar.

Es la responsabilidad de cada estudiante atleta llenar y entregar un reporte de su examen medico documentado en un formulario aprobado por el distrito escolar. Este formulario debe tener fecha y firma de su medico de familia y debe ser entregado al departamento de enfermeria de su colegio antes del comienzo de la temporada de deportes. El examen fisico debe ser obtenido durante el ano academico y el historial de salud debe ser revisado/completado durante los primeros 60 dias de la primera practica.

El cuestionario de la Historia Medica debe ser completado por el padre/guardiante, no por el estudiante. Después ser completado, debe llevarlo a la oficina de su medico de familia, quien para completar el examen medico.

Todas las formas de examen fisico de lo escuela intermedia completado debe ser devuelto a la enfermera de la escuela en su edificio. Todas las formas de los estudios secundarios deben ser devueltos al Head Coach, fisicos, a la Oficina de Deportes. los formularios incompletos no entrenador seran aceptados y seran devueltos a usted.

Después que se ha verificado que la informacion de los formularios es correcta, esta se presentara a nuestra junta medico. El doctor lo revisara y aprobara yo desaparabo la participacion del estudiante.

Los padres / tutores seran notificados si su hijo(a) ha sido elegido para participar en las actividades deportivas, a través del entrenador de su hijo(a).

* Tenga en cuenta que el estudiante no participara en ningun programa atlético hasta que este PROCESO HA SIDO COMPLETADO.
In order to participate in NJSIAA and School sponsored extra-curricular activities such as athletics, a physical form and permission slip must be correctly completed and turned in to the coach, nurse’s office, or athletic office. This physical form and permission slip must be **COMPLETELY** filled out before it goes to the school’s doctor for verification. If **ANY** of the physical form and permission slip is left blank or is incorrectly completed, it will be returned to you.

- This is a **LEGAL DOCUMENT**-only blue or black pen allowed.

- Parents/Guardians-must sign and date all required signature areas on the form.

- Parents/Guardians- Students attending the FREE school district physical: Physical dates, times and locations will be announced. Be advised that athletic physicals will take place after school and on Saturday’s. Be prepared for a 2 hour plus wait.

- Parents/Guardians-All students choosing to go to their own doctor must have the doctor complete the State Physical Form. Please make sure the doctor completes what is on the form and he/she must sign and USE THEIR OFFICIAL DOCTOR OFFICE STAMP. **A COPY OF THEIR CERTIFICATE AFTER COMPLETION OF THE NJDOE REQUIRED STUDENT ATHLETE CARDIAC ASSESSMENT PROFESSIONAL DEVELOPMENT MODULE DOES NOT NEED BE ATTACHED.**

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**NEW REQUIREMENT**

*Student-Athlete Cardiac Assessment Professional Development Module*

*The NJDOE, in collaboration with the NJDOH and in consultation with the New Jersey Chapter AAP, the New Jersey Chapter AAFP, the American Heart Association (AHA) and the New Jersey Chapter American College of Cardiology (ACC), has developed the Student-Athlete Cardiac Assessment Professional Development module to increase the assessment skills of those health care practitioners who perform student-athlete physical examinations and screenings. A physician, APN, or PA who performs a student’s annual physical examination prior to the student’s participation in a school-sponsored interscholastic or intramural athletic team or squad, is required to complete the professional development module. The physician, APN, or PA will be able to download and print a certificate upon completion of the module.*
MEDICAL COVERAGE

Due to change in the N.J. Administrative Code (N.J.A.C. 6A: 16:22), each student medical examination shall be conducted at the medical home (student’s family physician or healthcare provider) of the student. For example, the student’s physician or nurse practitioner clinical nurse specialist may be acceptable.

If a student does not have a medical home (doctor), or if the parent/guardian gives consent, the school physician can perform the student medical examination in a district school health office, after the parent/guardian completes and signs the form below.

By signing this form, I give permission for my son/daughter:

Student’s Name ____________________________ Sport ____________________________
to receive a sports physical exam from the district physician in a district school health office.

Parent/Guardian Signature ____________________________ Date __________
I have read the rules and regulations pertaining to the Elizabeth High School or Middle School Interscholastic Athletic Training/Participation and agree to comply with the rules and regulations as stated herein. I understand and agree that participation in co-curricular activities, such as interscholastic athletics, is a privilege, not a right. I further understand and agree that this privilege may be revoked at any time if I violate the rules and regulations governing student conduct contained in the Student Handbook, or in the policies, and regulations of the Elizabeth Board of Education, whether or not I am (1) in school; (2) participating in a school activity on or off school grounds; or (3) out-of-school, even when school is not in session.

Print Student Name: __________________________________________

Student ID#: ____________________ School: ________________________

Student Athlete’s Signature: ____________________________________ Date: ________________________

PARENT/GUARDIAN AGREEMENT AND ACKNOWLEDGEMENT

I acknowledge and agree that my child’s participation in any co-curricular activity at Elizabeth High School is conditioned upon my child’s compliance with rules, regulations, and policies identified above and may be revoked for violation of these rules, regulations, and policies.

Print Parent/Guardian Name: ____________________________________

Parent/Guardian Signature: __________________________ Date: __________________________
This is to certify that I give permission for my son/daughter to be photographed or videotaped by Board of Education representatives and for the photos/videotapes to be used in Board of Education Publications, displays, television displays, video streaming or news releases. Upon occasion, local newspaper or television reporters visit our schools/games. I hereby give permission for my child to be photographed by representatives from the media and for the photos/videotape to be used on local television broadcasts, video streaming, or in area newspapers. I understand that my child will not be interviewed by any newspaper or television reporter on Board of Education property without my consent.

La presente es para certificar que doy mi autorización para que mi hijo/hija sea filmado o fotografiado por los medios de comunicación como periódicos locales, el streaming de video o reporteros de la televisión que visitan nuestras escuelas de la Junta de Educación. En ocasiones periódicos locales o reporteros de televisión visitan nuestras escuelas. Por medio de la presente doy mi permiso para que mi hijo/hija sea fotografiado o entrevistado por los medios de comunicación y que las fotos y/o filmaciones puedan ser utilizadas por la televisión local, el streaming de video, o periódicos del área.

Tengo entendido que mi hijo/hija no va a ser entrevistado por ningún reportero de televisión o prensa local en la propiedad de la Junta de Educación sin mi consentimiento.

Please check one response:
(Por favor marque una respuesta) YES (Sí) □ NO □

Student's name: (please print)
(Nombre del Estudiante: (letra de molde)

Student's ID#: School
(Estudiante ID) (Escuela)

Print name of Parent/Guardian:
(Nombre del Padre/Guardian: (letra de molde)

Signature of Parent/Guardian: Date:
(Firma del Padre/Guardian) (Fecha)
A concussion is a brain injury that can be caused by a blow to the head or body that disrupts normal functioning of the brain. Concussions are a type of Traumatic Brain Injury (TBI), which can range from mild to severe and can disrupt the way the brain normally functions. Concussions can cause significant and sustained neuropsychological impairment affecting problem solving, planning, memory, attention, concentration, and behavior.

The Centers for Disease Control and Prevention estimates that 300,000 concussions are sustained during sports related activities nationwide, and more than 62,000 concussions are sustained each year in high school contact sports. Second-impact syndrome occurs when a person sustains a second concussion while still experiencing symptoms of a previous concussion. It can lead to severe impairment and even death of the victim.

Legislation (P.L. 2010, Chapter 94) signed on December 7, 2010, mandated measures to be taken in order to ensure the safety of K-12 student-athletes involved in interscholastic sports in New Jersey. It is imperative that athletes, coaches, and parent/guardians are educated about the nature and treatment of sports related concussions and other head injuries. The legislation states that:

- All Coaches, Athletic Trainers, School Nurses, and School/Team Physicians shall complete an Interscholastic Head Injury Safety Training Program by the 2011-2012 school year.
- All school districts, charter, and non-public schools that participate in interscholastic sports will distribute annually this educational fact to all student athletes and obtain a signed acknowledgement from each parent/guardian and student-athlete.
- Each school district, charter, and non-public school shall develop a written policy describing the prevention and treatment of sports-related concussion and other head injuries sustained by interscholastic student-athletes.
- Any student-athlete who participates in an interscholastic sports program and is suspected of sustaining a concussion will be immediately removed from competition or practice. The student-athlete will not be allowed to return to competition or practice until he/she has written clearance from a physician trained in concussion treatment and has completed his/her district’s graduated return-to-play protocol.

Quick Facts
- Most concussions do not involve loss of consciousness
- You can sustain a concussion even if you do not hit your head
- A blow elsewhere on the body can transmit an “impulsive” force to the brain and cause a concussion

Signs of Concussions (Observed by Coach, Athletic Trainer, Parent/Guardian)
- Appears dazed or stunned
- Forgets plays or demonstrates short term memory difficulties (e.g. unsure of game, opponent)
- Exhibits difficulties with balance, coordination, concentration, and attention
- Answers questions slowly or inaccurately
- Demonstrates behavior or personality changes
- Is unable to recall events prior to or after the hit or fall

Symptoms of Concussion (Reported by Student-Athlete)
- Headache
- Nausea/vomiting
- Balance problems or dizziness
- Double vision or changes in vision
- Sensitivity to light/sound
- Feeling of sluggishness or fogginess
- Difficulty with concentration, short term memory, and/or confusion
What Should a Student-Athlete do if they think they have a concussion?

- Don't hide it. Tell your Athletic Trainer, Coach, School Nurse, or Parent/Guardian.
- Report it. Don’t return to competition or practice with symptoms of a concussion or head injury. The sooner you report it, the sooner you may return-to-play.
- Take time to recover. If you have a concussion your brain needs time to heal. While your brain is healing you are much more likely to sustain a second concussion. Repeat concussions can cause permanent brain injury.

What can happen if a student-athlete continues to play with a concussion or returns to play to soon?

- Continuing to play with the signs and symptoms of a concussion leaves the student-athlete vulnerable to second impact syndrome.
- Second impact syndrome is when a student-athlete sustains a second concussion while still having symptoms from a previous concussion or head injury.
- Second impact syndrome can lead to severe impairment and even death in extreme cases.

Should there be any temporary academic accommodations made for Student-Athletes who have suffered a concussion?

- To recover cognitive rest is just as important as physical rest. Reading, texting, testing—even watching movies can slow down a student-athletes recovery.
- Stay home from school with minimal mental and social stimulation until all symptoms have resolved.
- Students may need to take rest breaks, spend fewer hours at school, be given extra time to complete assignments, as well as being offered other instructional strategies and classroom accommodations.

Student-Athletes who have sustained a concussion should complete a graduated return-to-play before they may resume competition or practice, according to the following protocol:

The Elizabeth School district uses the IMPACT (Immediate Post Concussion Assessment and Cognitive Testing) system to acquire baseline testing on all of our high school athletes. The test involves an online, computerized exam that each athlete takes prior to the athletic season.

If your son/daughter is believed to have suffered a concussion during competition, the exam will be administered a second time and the data will be compared to the baseline test administered by your physician. This information is then used as a tool to assist the athletic training staff and treating physician in determining the extent of the injury, in monitoring recovery, and in making the following safe return to play decisions:

- Step 1: Completion of a full day of normal cognitive activities (school day, studying for tests, watching practice, interacting with peers) without reemergence of any signs or symptoms. If no return of symptoms, next day advance.
- Step 2: Light Aerobic exercise, which includes walking, swimming, and stationary cycling, keeping the intensity below 70% maximum heart rate. No resistance training. The objective of this step is increased heart rate.
- Step 3: Sport-specific exercise including skating, and/or running: no head impact activities. The objective of this step is to add movement.
- Step 4: Non contact training drills (e.g. passing drills). Student-athlete may initiate resistance training.
- Step 5: Following medical clearance (consultation between school health care personnel and student-athlete’s physician), participation in normal training activities. The objective of this step is to restore confidence and assess functional skills by coaching and medical staff.
- Step 6: Return to play involving normal exertion or game activity.


Signature of Student-Athlete ___________________________ Print Student-Athlete’s Name ___________________________ Date __________

Signature of Parent/Guardian ___________________________ Print Parent/Guardian’s Name ___________________________ Date __________
NJSIAA STEROID TESTING POLICY

CONSENT TO RANDOM TESTING

In Executive Order 72, issued December 20, 2005, Governor Richard Codey directed the New Jersey Department of Education to work in conjunction with the New Jersey State Interscholastic Athletic Association (NJSIAA) to develop and implement a program of random testing for steroids, of teams and individuals qualifying for championship games.

Beginning in the Fall, 2006 sports season, any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances on the attached page, without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition. The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing.

By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that, if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

Signature of Student-Athlete   Print Student-Athlete's Name   Date

Signature of Parent/Guardian   Print Parent/Guardian's Name   Date

May 1, 2010
**Preparticipation Physical Evaluation**

**The Athlete with Special Needs: Supplemental History Form**

Date of Exam __________________________ Date of birth __________________________

Name __________________________ Sex __________________________ Grade __________________________

School __________________________ Sport(s) __________________________

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 __________________________

| 6. Do you regularly use a brace, assistive device, or prosthesis? | __________________________ |
| 7. Do you use any special brace or assistive device for sports? | __________________________ |
| 8. Do you have any rashes, pressure sores, or any other skin problems? | __________________________ |
| 9. Do you have a hearing loss? Do you use a hearing aid? | __________________________ |
| 10. Do you have a visual impairment? | __________________________ |
| 11. Do you use any special devices for bowel or bladder function? | __________________________ |
| 12. Do you have burning or discomfort when urinating? | __________________________ |
| 13. Have you had autonomic dysreflexia? | __________________________ |
| 14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness? | __________________________ |
| 15. Do you have muscle spasticity? | __________________________ |
| 16. Do you have frequent seizures that cannot be controlled by medication? | __________________________ |

Explain "yes" answers here __________________________

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

| Atlantoaxial Instability | __________________________ |
| X-ray evaluation for atlantoaxial Instability | __________________________ |
| Dislocated joints (more than one) | __________________________ |
| Easy bleeding | __________________________ |
| Enlarged spleen | __________________________ |
| Hepatitis | __________________________ |
| Osteopenia or osteoporosis | __________________________ |
| Difficulty controlling bowel | __________________________ |
| Difficulty controlling bladder | __________________________ |
| Numbness or tingling in arms or hands | __________________________ |
| Numbness or tingling in legs or feet | __________________________ |
| Weakness in arms or hands | __________________________ |
| Weakness in legs or feet | __________________________ |
| Recent change in coordination | __________________________ |
| Recent change in ability to walk | __________________________ |
| Spina bifida | __________________________ |
| Latex allergy | __________________________ |

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

Está página debe ser completada por los padres de todos los atletas!!!

This page must be completed by parents of all athletes even if there are no special needs!!!
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 copy of this form in the chart.)

Date of Exam: ____________________  Date of birth: ____________________

Name: ____________________  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.

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dosage</th>
<th>Frequency</th>
</tr>
</thead>
</table>

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.

**MEDICAL QUESTIONS**

26. Do you cough, wheeze, or have difficulty breathing during or after exercise?

27. Have you ever used an inhaler or taken asthma medication?

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 brain injury or a fractured brain in the brain area?

31. Have you had infectious mononucleosis (mononucleosis) within the last month?

32. Do you have any rash, 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 ill 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?

**HEART HEALTH QUESTIONS ABOUT YOUR FAMILY**

49. Has a doctor ever checked your heart? (For example, ECG/ECG, echocardiogram)

**BONE AND JOINT QUESTIONS**

56. Have you ever had a bone, muscle, ligament, or tendon that caused you to miss practice or a game?

57. Have you ever had any broken or fractured bones or dislocated joints?

58. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?

59. Have you ever had a stress fracture?

60. Have you ever had a joint injury that bothers you?

61. Do you regularly use a brace, orthotics, or other assistive device?

62. Do you have a bone, muscle, or joint injury that bothers you?

63. Do any of your joints become painful, swollen, feel warm, or look red?

64. Do you have any history of juvenile arthritis or connective tissue disease?

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: ____________________

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New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71
EVALUACIÓN FÍSICA – PRE-PARTICIPACIÓN
FORMULARIO DE HISTORIAL MÉDICO
(Nota: Este formulario debe ser llenado por el paciente y padre/madre antes de ver al doctor. El doctor debe mantener este formulario en el expediente)

Fecha del examen __________________________ Fecha de nacimiento __________________________

<table>
<thead>
<tr>
<th>Sexo</th>
<th>Edad</th>
<th>Grado</th>
<th>Escuela</th>
<th>Deporte(s)</th>
</tr>
</thead>
</table>

| Medicamentos y Alergias: Por favor, indica todos los medicamentos con y sin receta médica y suplementos (herbasales y nutricionales) que estás tomando actualmente |
|------|------|-------|---------|------------|
|      |      |       |         |            |

<table>
<thead>
<tr>
<th>Tienes alergias</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Si la respuesta es sí, por favor identifica abajo la alergia específica.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicamentos</td>
<td>Polen</td>
<td>Comida</td>
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<tr>
<td>Otro:</td>
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Explica abajo las preguntas respondidas con un “sÍ”. Pon un círculo alrededor de las preguntas cuyas respuestas desconoces.

### PREGUNTAS GENERALES

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<tr>
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<tbody>
<tr>
<td>1. ¿Alguna vez un doctor te ha prohibido o limitado tu participación en deportes por alguna razón?</td>
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<tr>
<td>2. ¿Tienes actualmente alguna condición médica? Si es así, por favor identifica abajo:</td>
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<tr>
<td>Asma</td>
<td>Anemia</td>
<td>Diabetes</td>
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<td>Infecciones</td>
<td>Otro:</td>
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<td>3. ¿Has sido ingresado alguna vez en el hospital?</td>
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<tr>
<td>4. ¿Has tenido cirugía alguna vez?</td>
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### PREGUNTAS SOBRE LA SALUD DE TU CORAZÓN

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<tr>
<td>5. ¿Te has desmayado alguna vez o casi te has desmayado DURANTE o DESPUÉS de hacer ejercicio?</td>
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<tr>
<td>6. ¿Has tenido alguna vez molestias, dolor o presión en el pecho cuando haces ejercicio?</td>
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<tr>
<td>7. ¿Alguna vez has sentido que tu corazón se acelera o tiene latidos irregulares cuando haces ejercicio?</td>
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<tr>
<td>8. ¿Te ha dicho alguna vez un doctor que tienes un problema de corazón? Si es así, marca el que sea pertinente</td>
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<tr>
<td>Presión alta</td>
<td>Un soplo en el corazón</td>
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<td>Nivel alto de colesterol</td>
<td>Una infección en el corazón</td>
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<tr>
<td>Enfermedad de Kawasaki</td>
<td>Otro:</td>
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<tr>
<td>9. ¿Alguna vez un doctor te ha pedido que te hagas pruebas de corazón? (Por ejemplo, ECG/EGK, ecocardiograma)</td>
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<td>10. ¿Te sientes mareado o te falta el aire más de lo esperado cuando haces ejercicio?</td>
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<td>11. ¿Has tenido alguna vez una convulsión inexplicable?</td>
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<tr>
<td>12. ¿Te cansas más o te falta el aire con más rapidez que a tus amigos cuando haces ejercicio?</td>
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### PREGUNTAS SOBRE LA SALUD DEL CORAZÓN DE TU FAMILIA

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<tr>
<td>13. ¿Has tenido algún familiar que ha fallecido a causa de problemas de corazón o que haya fallecido de forma inexplicable o inesperada antes de la edad de 50 años (Incluyendo ahogo, accidente de tráfico inesperado, o síndrome de muerte súbita infantil)</td>
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<td>14. ¿Sufre alguien en tu familia de cardiomiopatía hipertrófica, síndrome Marfan, cardiomiopatía arritmogénica ventricular derecha, síndrome de QT corte, síndrome de Brugada, o taquicardia ventricular polimórfica catecolaminérgica?</td>
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<td>15. ¿Alguno en tu familia tiene problemas de corazón, un marcapasos o un desfibrilador implantado en su corazón?</td>
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<td>16. ¿Ha sufrido alguien en tu familia un desmayo inexplicable, convulsiones inexplicables, o casi se ha ahogado?</td>
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### PREGUNTAS SOBRE HUESOS Y ARTICULACIONES

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<tr>
<td>17. ¿Alguna vez has perdido un entrenamiento o partido porque te habías lesionado un hueso, músculo, ligamento o tendón?</td>
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<td>18. ¿Has roto o fracturado alguna vez un hueso o dislocado una articulación?</td>
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<td>19. ¿Has sufrido alguna vez una lesión que haya requerido radiografías, resonancia (MRI) tomografía, inyecciones, terapia, un soporte ortopédico/tabilla, un yeso, o muletas?</td>
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<td>20. ¿Has sufrido alguna vez una fractura por estrés?</td>
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<td>21. ¿Has tenido alguna vez una radiografía para diagnosticar inestabilidad del cuello o inestabilidad atlantoaxial? (Síndrome de Down o enanismo)</td>
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<td>22. ¿Usas regularmente una tabilla/soporte ortopédico, ortesis, u otro dispositivo de asistencia?</td>
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<tr>
<td>23. ¿Tienes una lesión en un hueso, músculo o articulación que te esté molestando?</td>
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<td>24. ¿Algunas de tus articulaciones se vuelven dolorosas, inflamadas, se sienten calientes, o se ve enrojecidas?</td>
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<td>25. ¿Tienes historial de artritis juvenil o enfermedad del tejido conectivo?</td>
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(Por favor, continúa)
### PREGUNTAS MÉDICAS

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<tr>
<td>26.</td>
<td>¿Tienes síntomas de dificultad para respirar durante o después de hacer ejercicio?</td>
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<td>27.</td>
<td>¿Has usado algún medicamento para el asma?</td>
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<td>28.</td>
<td>¿Hay alguien en tu familia que tenga asma?</td>
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<td>29.</td>
<td>¿Has tenido mononucleosis (mono) en los últimos 3 meses?</td>
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<td>30.</td>
<td>¿Haces ejercicio con una lesión o contusión en la cabeza?</td>
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<td>31.</td>
<td>¿Has tenido herpes o infección de SARM en la piel?</td>
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<td>32.</td>
<td>¿Has tenido algún sarpullido, llagas, o otros problemas en la piel?</td>
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<td>33.</td>
<td>¿Has tenido una lesión o contusión en la cabeza?</td>
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<td>34.</td>
<td>¿Has tenido una lesión o contusión en la cabeza?</td>
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<td>35.</td>
<td>¿Has tenido una lesión o contusión en la cabeza?</td>
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<td>36.</td>
<td>¿Tienes un historial de un trastorno de convulsiones?</td>
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<td>37.</td>
<td>¿Tienes dolor de cabeza cuando haces ejercicio?</td>
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<td>38.</td>
<td>¿Has tenido entumecimiento, hormigueo, o debilidad en los brazos o piernas después de haber sufrido un golpe o haberte caído?</td>
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<td>39.</td>
<td>¿Has tenido alguna vez un trastorno alimenticio?</td>
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<td>40.</td>
<td>¿Tienes alguna preocupación de la que quieras hablar con el doctor?</td>
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### SÓLO PARA MUJERES

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<tr>
<td>52.</td>
<td>¿Has tenido alguna vez el periodo menstrual?</td>
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<td>53.</td>
<td>¿Qué edad tenías cuando tuviste tu primer periodo menstrual?</td>
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<td>54.</td>
<td>¿Cuántos periodos has tenido en los últimos 12 meses?</td>
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Explica aquí las preguntas a las que respondiste con un “sí”

---

Yo por la presente declaro que, según mi más leal saber y entender, mis respuestas a las preguntas anteriores están completas y son correctas.

Firma del atleta

Firma del padre/madre/tutor legal

Fecha

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 5-16).

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<tr>
<td>- Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlexia, myopia, MVP, aortic insufficiency)</td>
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<td>- Pupils equal</td>
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<td>- Murmurs (auscultation standing, supine, +/- Valsalva)</td>
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<td>- Location of point of maximal impulse (PMI)</td>
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<td>- Simultaneous femoral and radial pulses</td>
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<td>- HSV lesions suggestive of MRSA, linea corporis</td>
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<td>Feet/ toes</td>
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<td>Functional</td>
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<td>- Duck-walk, single leg hop</td>
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</table>

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
*Consider lab 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

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
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 evaluation or treatment for ____________________________

□ Not cleared
□ Pending further evaluation
□ For any sports
□ For certain sports ____________________________
Reason ____________________________

Recommendations ____________________________
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EMERGENCY INFORMATION

Allergies ____________________________
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Other Information ____________________________
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HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on ____________ (Date)
Approved _______ Not Approved _______
Signature: ____________________________

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 ____________________________

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

18
**Asthma Treatment Plan – Student**

(This asthma action plan meets N.J. Law N.J.S.A. 18A:40-12.8 (Physician's Orders))

**HEALTHY (Green Zone)**

- **You have all these:**
  - Breathing is good
  - No cough or wheeze
  - Sleep through the night
  - Can work, exercise, and play

And/or Peak flow above

**CAUTION (Yellow Zone)**

- **You have any of these:**
  - Cough
  - Mild wheeze
  - Tight chest
  - Coughing at night
  - Other:

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from to

**EMERGENCY (Red Zone)**

- Your asthma is getting worse fast:
  - Quick-relief medicine did not help within 15-20 minutes
  - Breathing is hard or fast
  - Nose opens wide, ribs show
  - Trouble walking and talking
  - Lips blue, fingernails blue
  - Other:

And/or Peak flow below

**Take daily control medicine(s). Some inhalers may be more effective with a “spacer” – use if directed.**

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advair® HFA [45, 115, 230]</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Aerospin™ [80, 160]</td>
<td>1 puffs twice a day</td>
</tr>
<tr>
<td>Alvesco® [80, 160]</td>
<td>1 puffs twice a day</td>
</tr>
<tr>
<td>Dulera® [100, 200]</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Flovent® [44, 110, 220]</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Qvar® [40, 80]</td>
<td>1 puffs twice a day</td>
</tr>
<tr>
<td>Symbicort® [80, 160]</td>
<td>1 puffs twice a day</td>
</tr>
<tr>
<td>Advair Diskus® [100, 250]</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Asmanex® [110, 220]</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Flovent® Diskus® [50, 100]</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Pulmicort Flexhaler® [90, 180]</td>
<td>1 inhalation twice a day</td>
</tr>
<tr>
<td>Pulmicort Respules® (Budesonide) [0.25, 0.5, 1.0]</td>
<td>1 tablet nebulized once or twice a day</td>
</tr>
<tr>
<td>Singulair® (Montelukast) [4, 5, 10 mg]</td>
<td>1 tablet daily</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

Remember to rinse your mouth after taking inhaled medicine.  
If exercise triggers your asthma, take puffs minutes before exercise.

**Continue daily control medicine(s) and ADD quick-relief medicine(s).**

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol MDI (Pro-air® or Proventil® or Ventolin®)</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex®</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Albuterol [1.25, 2.5 mg]</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Duoneb®</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex® (Levalbuterol) [0.31, 0.63, 1.25 mg]</td>
<td>1 unit nebulized every 4 hours as needed</td>
</tr>
<tr>
<td>Combivent Respiné®</td>
<td>1 inhalation 4 times a day</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Take these medicines NOW and CALL 911. Asthma can be a life-threatening illness. Do not wait!**

<table>
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<tr>
<th>MEDICINE</th>
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</tr>
</thead>
<tbody>
<tr>
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<td>1 unit nebulized every 20 minutes</td>
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<tr>
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<td>1 inhalation 4 times a day</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

Permission to Self-administer Medication:  
☐ This student is capable and has been instructed in the proper method of self-administering the non-nebulized inhaled medications named above in accordance with N.J. Law.  
☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE:  
Physician's Orders:  
DATE:  
PARENT/GUARDIAN SIGNATURE:  
PHYSICIAN STAMP:

Make a copy for parent and for physician file, send original to school nurse or child care provider.
Asthma Treatment Plan – Student Parent Instructions

The PACNJ Asthma Treatment Plan is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. Parents/Guardians: Before taking this form to your Health Care Provider, complete the top left section with:
   - Child’s name
   - Child’s date of birth
   - Child’s doctor’s name & phone number
   - An Emergency Contact person’s name & phone number
   - Parent/Guardian’s name & phone number

2. Your Health Care Provider will complete the following areas:
   - The effective date of this plan
   - The medical information for the Healthy, Caution and Emergency sections
   - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
   - Your Health Care Provider may check “OTHER” and:
     - Write in asthma medications not listed on the form
     - Write in additional medications that will control your asthma
     - Write in generic medications in place of the name brand on the form
   - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:
   - Child’s peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
   - Child’s asthma triggers on the right side of the form
   - Permission to Self-administer Medication section at the bottom of the form: Discuss your child’s ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. Parents/Guardians: After completing the form with your Health Care Provider:
   - Make copies of the Asthma Treatment Plan and give the signed original to your child’s school nurse or child care provider
   - Keep a copy easily available at home to help manage your child’s asthma
   - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child’s health care provider concerning my child’s health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature

Phone

Date

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be ALLOWED to carry the following medication for self-administration in school pursuant to N.J.A.C. 6A:18-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administering the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ I DO NOT request that my child self-administer his/her asthma medication.

Parent/Guardian Signature

Phone

Date
ACKNOWLEDGEMENT AND CONSENT FORM

Name of Student-Athlete ___________________________ School ___________________________

1. I hereby acknowledge receipt of the following concussion information: The NJSIAA and Elizabeth BOE Parent-Guardian Concussion Policy Acknowledgement Form. We further understand that the Elizabeth Athletic Department is following said Guidelines and Management Plan for head-related injuries.

   Parent Initials ___________________________

2. I hereby acknowledge receipt of the Sudden Cardiac Death in Young Athletes Pamphlet.

   Parent Initials ___________________________

3. I hereby acknowledge receipt of the NJSIAA's Steroid Testing Policy and List of Banned Drug Classes and we hereby consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

   Parent Initials ___________________________

4. We hereby acknowledge receipt of the NJSIAA's Use and Misuse of Opioid Drugs Fact Sheet.

   Parent Initials ___________________________

5. I hereby acknowledge that the Student-Athlete Code of Conduct has been read and understand the rules and guidelines stated in this document. We hereby agree to participate under these guidelines.

   Parent Initials ___________________________

6. Parent signature and date is on each page that has the following symbols

   Please Sign Here Please Sign & Date

   Parent Initials ___________________________

7. Doctors signature and stamp is on Clearance Form (Also on Asthma Action Form if your child has asthma)

   Parent Initials ___________________________

Print Student-Athlete's Name ___________________________ Signature of Student-Athlete ___________________________ Date ___________________________

Print Parent/Guardian's Name ___________________________ Signature of Parent/Guardian ___________________________ Date ___________________________
SIGNS AND SYMPTOMS OF CONCUSSION

Concussions can appear in many different ways. Listed below are some of the signs and symptoms frequently associated with concussions. Most signs, symptoms, and abnormalities after a concussion fall into the four categories listed below. A coach, parent, or other person who knows the athlete well can often detect these problems by observing the athlete and/or by asking a few relevant questions of the athlete, official, or teammate who was on the field or court at the time of the concussion. Below are some suggested observations and questions a non-medical individual can use to help determine whether an athlete has suffered a concussion and how urgently he or she should be sent for appropriate medical care.

1. PROBLEMS IN BRAIN FUNCTION:
   a. Confused state – dazed look, vacant stare or confusion about what happened or is happening.
   b. Memory problems – can’t remember assignment on play, opponent, score of game, or period of the game; can’t remember how or with whom he or she traveled to the game, what he or she was wearing, what was eaten for breakfast, etc.
   c. Symptoms reported by athlete – Headache, nausea or vomiting; blurred or double vision; oversensitivity to sound, light or touch; ringing in ears; feeling foggy or groggy; dizziness.
   d. Lack of sustained attention – difficulty sustaining focus adequately to complete a task, a coherent thought or a conversation.

2. SPEED OF BRAIN FUNCTION: Slow response to questions, slow slurred speech, incoherent speech, slow body movements and slow reaction time.

3. UNUSUAL BEHAVIORS: Behavior in a combative, aggressive or very silly manner; atypical behavior for the individual; repeatedly asking the same question over and over; restless and irritable behavior with constant motion and attempts to return to play; reactions that seem out of proportion and inappropriate; and having trouble resting or “finding a comfortable position.”

4. PROBLEMS WITH BALANCE AND COORDINATION: Dizziness, slow clumsy movements, inability to walk a straight line or balance on one foot with eyes closed.

IF NO MEDICAL PERSONNEL ARE ON HAND AND AN INJURED ATHLETE HAS ANY OF THE ABOVE SYMPTOMS, HE OR SHE SHOULD BE SENT FOR APPROPRIATE MEDICAL CARE.

CHECKING FOR CONCUSSION:

The presence of any of the signs or symptoms that are listed in this brochure suggest a concussion has most likely occurred. In addition to observation and direct questioning for symptoms, medical professionals have a number of other instruments to evaluate attention, processing speed, memory, balance, reaction time, and ability to think and analyze information (called executive brain function). These are the brain functions that are most likely to be adversely affected by a concussion and most likely to persist during the post-concussion period.

If an athlete seems “clear” he or she should be exercised enough to increase the heart rate and then evaluate if any symptoms return before allowing that athlete to practice or play.

Computerized tests that can evaluate brain function are now being used by some medical professionals at all levels of sports from youth to professional and elite teams. They provide an additional tool to assist physicians in determining when a concussed athlete appears to have healed enough to return to school and play. This is especially helpful when dealing with those athletes denying symptoms in order to play sooner.

For non-medical personnel, the Centers for Disease Control and Prevention (CDC) has also developed a tool kit (“Heads Up: Concussion In High School Sports”), which has been made available to all high schools, and has information for coaches, athletes and parents. The NFHS is proud to be a co-sponsor of this initiative.

PREVENTION

Although all concussions cannot be prevented, many can be minimized or avoided. Proper coaching techniques, good officiating of the existing rules, and use of properly fitted equipment can minimize the risk of head injury. Although the NFHS advocates the use of mouthguards in nearly all sports and mandates them in some, there is no convincing scientific data that their use will prevent concussions.


References:
INTRODUCTION
Concussions are a common problem in sports and have the potential for serious complications if not managed correctly. Even what appears to be a “minor ding or bell ringer” has the real risk of catastrophic results when an athlete is returned to action too soon. The medical literature and lay press are reporting instances of death from “second impact syndrome” when a second concussion occurs before the brain has recovered from the first one regardless of how mild both injuries may seem.

At many athletic contests across the country, trained and knowledgeable individuals are not available to make the decision to return concussed athletes to play. Frequently, there is undue pressure from various sources (parents, player and coach) to return a valuable athlete to action. In addition, often there is unwillingness by the athlete to report headaches and other findings because the individual knows it would prevent his or her return to play.

Outlined below are some guidelines that may be helpful for parents, coaches and others dealing with possible concussions. Please bear in mind that these are general guidelines and must not be used in place of the central role that physicians and athletic trainers must play in protecting the health and safety of student-athletes.

SIDELINE MANAGEMENT OF CONCUSSION

1. Did a concussion take place? Based on mechanism of injury, observation, history and unusual behavior and reactions of the athlete, even without loss of consciousness, assume a concussion has occurred if the head was hit and even the mildest of symptoms occur. (See other side for signs and symptoms)

2. Does the athlete need immediate referral for emergency care? If confusion, unusual behavior or responsiveness, deteriorating condition, loss of consciousness, or concern about neck and spine injury exist, the athlete should be referred at once for emergency care.

3. If no emergency is apparent, how should the athlete be monitored? Every 5-10 minutes, mental status, attention, balance, behavior, speech and memory should be examined until stable over a few hours. If appropriate medical care is not available, an athlete even with mild symptoms should be sent for medical evaluation.

4. No athlete suspected of having a concussion should return to the same practice or contest, even if symptoms clear in 15 minutes.

MANAGEMENT OF CONCUSSIONS AND RETURN TO PLAY

(See “SIDELINE DECISION-MAKING” Below)

Increasing evidence is suggesting that initial signs and symptoms, including loss of consciousness and amnesia, may not be very predictive of the true severity of the injury and the prognosis or outcome. More importance is being assigned to the duration of such symptoms and this, along with data showing symptoms may worsen some time after the head injury, has shifted focus to continued monitoring of the athlete. This is one reason why these guidelines no longer include an option to return an athlete to play even if clear in 15 minutes and why there is no discussion about the “Grade” of the concussion.

Any athlete who is removed from play because of a concussion should have medical clearance from an appropriate health care professional before being allowed to return to play or practice. The Second International Conference on Concussion held in Prague recommends an athlete should not return to practice or competition in sport until he or she is asymptomatic including after exercise.

Recent information suggests that mental exertion, as well as physical exertion, should be avoided until concussion symptoms have cleared. Premature mental or physical exertion may lead to more severe and more prolonged post concussion period. Therefore, the athlete should not study, play video games, do computer work or phone texting until his or her symptoms are resolving. Once symptoms are clear, the student-athlete should try reading for short periods of time. When 1-2 hours of studying can be done without symptoms developing, the athlete may return to school for short periods; gradually increasing until a full day of school is tolerated without return of symptoms.

Once the athlete is able to complete a full day of school work, without PE or other exertion, the athlete can begin the gradual return to play protocol as outlined below. Each step increases the intensity and duration of the physical exertion until all skills required by the specific sport can be accomplished without symptoms. These recommendations have been based on the awareness of the increased vulnerability of the brain to concussions occurring close together and of the cumulative effects of multiple concussions on long-term brain function. Research is now revealing some fairly objective and relatively easy-to-use tests which appear to identify subtle residual deficits that may not be obvious from the traditional evaluation. These identifiable abnormalities frequently persist after the obvious signs of concussion are gone and appear to have relevance to whether an athlete can return to play in relative safety. The significance of these deficits is still under study and the evaluation instruments represent a work in progress. They may be helpful to the professional determining return to play in conjunction with consideration of the severity and nature of the injury, the interval since the last head injury, the duration of symptoms before clearing and the level of play.
Sudden death in young athletes between the ages of 10 and 19 is very rare. What, if anything, can be done to prevent this kind of tragedy?

What is sudden cardiac death in the young athlete?

Sudden cardiac death is the result of an unexpected failure in proper heart function, usually (about 90% of the time) during or immediately after exercise without trauma. Since the heart stops pumping adequately, the athlete quickly collapses, loses consciousness, and ultimately dies unless normal heart rhythm is restored using an automated external defibrillator (AED).

How common is sudden death in young athletes?

Sudden cardiac death in young athletes is very rare. About 100 such deaths are reported in the United States per year. The chance of sudden death occurring to any individual high school athlete is about one in 200,000 per year.

Sudden cardiac death is more common in males than in females in football and basketball than in other sports and in African-Americans than in other races and ethnic groups.

What are the most common causes?

Research suggests that the main cause is a loss of proper heart rhythm, causing the heart to quiver instead of pumping blood to the brain and body. This is called ventricular fibrillation (ver-TEK-you-lar fil-bris-i-LAY-shun). The problem is usually caused by one of several cardiovascular abnormalities and electrical diseases of the heart that go unnoticed in healthy-appearing athletes.

The most common cause of sudden death in an athlete is hypertrophic cardiomyopathy (hin-per-TRIF-ik KAR-dee-oh-my-OP-a-thee), also called HCM. HCM is a disease of the heart, with abnormal thickening of the heart muscle, which can cause serious heart rhythm problems and blockages to blood flow. This genetic disease runs in families and usually develops gradually over many years.

The second most likely cause is congenital (con-JEN-i-tal), or present from birth, abnormalities of the coronary arteries. This means that these blood vessels are connected to the main blood vessel of the heart in an abnormal way. This differs from blockages that may occur when people get older (commonly called "coronary artery disease," which may lead to a heart attack).
# 2017-18 NJSIAA Banned Drugs

**IT IS YOUR RESPONSIBILITY TO CHECK WITH THE APPROPRIATE OR DESIGNATED ATHLETICS STAFF BEFORE USING ANY SUBSTANCE. THE INSTITUTION AND THE STUDENT-ATHLETE SHALL BE HELD ACCOUNTABLE FOR ALL DRUGS WITHIN THE BANNED DRUG CLASS REGARDLESS OF WHETHER THEY HAVE BEEN SPECIFICALLY IDENTIFIED.**

## The NJSIAA Bans the Following Classes of Drugs

<table>
<thead>
<tr>
<th>Stimulants</th>
<th>Street Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anabolic Agents</td>
<td>Peptide Hormones and Analogues</td>
</tr>
<tr>
<td>Alcohol and Beta</td>
<td>Anti-estrogens</td>
</tr>
<tr>
<td>Diuretics and Other Masking Agents</td>
<td>Beta-2 Agonists</td>
</tr>
</tbody>
</table>

**NOTE: ANY SUBSTANCE CHEMICALLY RELATED TO THESE CLASSES IS ALSO BANNED.**

### Drugs and Procedures Subject to Restrictions:

| Blood Doping | Beta-2 Agonists permitted only by prescription and inhalation |
| Manipulation of Urine Samples | Gene Doping |
| Local Anesthetics (under some conditions) | |

### NJSIAA Nutritional/Dietary Supplements Warning:
Before consuming any nutritional/dietary supplement product, review the product with the appropriate or designated athletics department staff.
- Dietary supplements are not well regulated and may cause a positive drug test result.
- Student-athletes have tested positive and lost their eligibility using dietary supplements.
- Many dietary supplements are contaminated with banned drugs not listed on the label.
- Any product containing a dietary supplement ingredient is taken at your own risk.

## Some Examples of NJSIAA Banned Substances in Each Drug Class

**Stimulants**
- Amphetamine (Adderall)
- Caffeine (guarana)
- Cocaine
- Ephedrine
- Fenfluramine (Fen)
- Methamphetamine
- Methylphenidate (Ritalin)
- Phentermine (phen)
- Pseudoephedrine (bitter orange)
- Methylenedioxamine, "bath salts" (mephedrone), Octopamine, DMBA, etc.

*Exceptions: phenylephrine and pseudoephedrine are not banned.*

**Anabolic Agents** (sometimes listed as a chemical formula, such as 3,4,7-androstane-trione)
- Androstenedione
- Boldenone
- Clenbuterol
- DHEA (7-Keto)
- Epitrenbolone
- Ethanolamine
- Mesterolone
- Methandienone
- Nandrolone
- Norandrostenolone
- Stanozolol
- Testosterone
- Trenbolone
- SARMS (ostarine), etc.

**Alcohol and Beta Blockers**
- Alcohol
- Atenolol
- Metoprolol
- Nadolol
- Pindolol
- Propranolol
- Timolol, etc.

**Diuretics (water pills) and Other Masking Agents**
- Bumetanide
- Chlorothiazide
- Furosemide
- Hydrochlorothiazide
- Probenecid
- Spironolactone (canrenone)
- Triamterene
- Trichlormethiazide, etc.

**Street Drugs**
- Heroin
- Marijuana
- Tetrahydrocannabinol (THC)
- Synthetic cannabinoids (e.g. spice, K2, JWH-018, JWH-073)

**Peptide Hormones and Analogues**
- Growth hormone (hGH)
- Human chorionic gonadotropin (hCG)
- Erythropoietin (EPO), etc.

**Anti-Estrogens**
- Anastrozole
- Tamoxifen
- Fomestane
- ATD
- Clomiphene
- SERMS (nalvadex), etc.

**Beta-2 Agonists**
- Bronchodilators: formoterol, salbutamol, salmeterol, iotiganime, norcoasclerine, etc.

**REMEMBER: ANY SUBSTANCE THAT IS CHEMICALLY RELATED TO THE CLASS, EVEN IF IT IS NOT LISTED AS AN EXAMPLE, IS ALSO BANNED! IT IS YOUR RESPONSIBILITY TO CHECK WITH THE APPROPRIATE OR DESIGNATED ATHLETICS STAFF BEFORE USING ANY SUBSTANCE.**
SPORTS-RELATED EYE INJURIES: AN EDUCATIONAL FACT SHEET FOR PARENTS

Participating in sports and recreational activities is an important part of a healthy, physically active lifestyle for children. Unfortunately, injuries can, and do, occur. Children are at particular risk for sustaining a sports-related eye injury and most of these injuries can be prevented. Every year, more than 30,000 children sustain serious sports-related eye injuries. Every 13 minutes, an emergency room in the United States treats a sports-related eye injury. According to the National Eye Institute, the sports with the highest rate of eye injuries are: baseball/softball, ice hockey, racquet sports, and basketball, followed by fencing, lacrosse, paintball and boxing.

Thankfully, there are steps that parents can take to ensure their children's safety on the field, the court, or wherever they play or participate in sports and recreational activities.

Approximately 90% of sports-related eye injuries can be prevented with simple precautions, such as properly fitting protective eyewear. Each sport has a certain type of recommended protective eyewear, as determined by the American Society for Testing and Materials (ASTM). Protective eyewear should sit comfortably on the face. Poorly fitted eyewear may be uncomfortable, and may not offer the best eye protection. Protective eyewear for sports includes, among other things, safety goggles and eyeshielding shades and must be made of polycarbonate lenses. A strong, shatterproof plastic offers better protection than are much stronger than regular lenses.

Healthcare providers are encouraged to encourage ophthalmologists, optometrists, and others to provide information to their patients about the importance of protective eyewear. For more information about what kind of eyewear to use in your sport, visit the National Eye Institute at http://www.nei.nih.gov/health/topics/eye_conditions-and-diseases/prevent-eye-conditions-prevent-sport-related-eye-injuries.htm. The American Academy of Ophthalmology offers tips on purchasing and fitting protective eyewear and can be found at http://www.preventblindness.org/preventitional-sports-eye-protectors.html. It is recommended that all children participate in sports where additional sports wear protective eyewear. Parents and coaches need to teach their athletes protective eyewear and properly gear up for the game. Protective eyewear are available in a variety of styles and colors. They provide eye protection in a variety of sports. Since many youth sports have a high risk of eye injuries, it is important that you ensure that their children wear safety glasses or goggles. Ophthalmologists recommend protective eyewear when they play sports.

The most common types of eye injuries that can result from sports injuries are blunt injuries, corneal abrasions and penetrating injuries.

- **Blunt injuries:** Blunt injuries occur when the eye is suddenly compressed by impact from an object. Blunt injuries, often caused by tennis balls, racquets, fists or elbows, sometimes cause a black eye or hyphema (bleeding in front of the eye). More serious blunt injuries often break bones near the eye, and may sometimes seriously damage important eye structures and/or lead to vision loss.

- **Corneal abrasions:** Corneal abrasions are painful scrapes on the outside of the eye, or the cornea. Most corneal abrasions eventually heal on their own, but a doctor can best assess the extent of the abrasion, and may prescribe medication to help control the pain. The most common cause of a sports-related corneal abrasion is being poked in the eye by a finger.

- **Penetrating injuries:** Penetrating injuries are caused by a foreign object piercing the eye. Penetrating injuries are very serious, and often result in severe damage to the eye. These injuries often occur when eyeglasses break while they are being worn. Penetrating injuries must be treated quickly in order to preserve vision.

### Signs or Symptoms of an Eye Injury

If a child sustains an eye injury, it is recommended that he/she receive immediate treatment from a licensed HCP (e.g., eye doctor) to reduce the risk of serious damage, including blindness. It is also recommended that the child, along with his/her parent or guardian, seek guidance from the HCP regarding the appropriate amount of time to wait before returning to sports competition or practice after sustaining an eye injury. The school nurse and the child's teachers should also be notified when a child sustains an eye injury. A parent or guardian should also provide the school nurse with a physician's note detailing the nature of the eye injury, any diagnosis, medical orders for the return to school, as well as any prescription(s) and/or treatment(s) necessary to promote healing, and the safe resumption of normal activities, including sports and recreational activities.

### What to do if a Sports-Related Eye Injury Occurs

According to the American Family Physician Journal, there are several guidelines that should be followed when students return to play after sustaining an eye injury. For example, students who have sustained significant ocular injury should receive a full examination and clearance by an ophthalmologist or optometrist. In addition, students should not return to play until the period of time recommended by their HCP has elapsed. For more minor eye injuries, the athletic trainer may determine that it is safe for a student to resume play based on the nature of the injury, and how the student feels. No matter what degree of eye injury is sustained, it is recommended that students wear protective eyewear when returning to play and immediately report any concerns with their vision to their coach and/or the athletic trainer.


OPIOID USE AND MISUSE
EDUCATIONAL FACT SHEET
Keeping Student-Athletes Safe

School athletics can serve an integral role in students' development. In addition to providing healthy forms of exercise, school athletics foster friendships and camaraderie, promote sportsmanship and fair play, and instill the value of competition.

Unfortunately, sports activities may also lead to injury and, in rare cases, result in pain that is severe or long-lasting enough to require a prescription opioid painkiller. It is important to understand that overdoses from opioids are on the rise and are killing Americans of all ages and backgrounds. Families and communities across the country are coping with the health, emotional and economic effects of this epidemic.

This educational fact sheet, created by the New Jersey Department of Education as required by state law (N.J.S.A. 18A:40-41.10), provides information concerning the use and misuse of opioid drugs in the event that a health care provider prescribes a student-athlete or cheerleader an opioid for a sports-related injury. Student-athletes and cheerleaders participating in an interscholastic sports program (and their parent or guardian, if the student is under age 18) must provide their school district written acknowledgment of their receipt of this fact sheet.

How Do Athletes Obtain Opioids?

In some cases, student-athletes are prescribed these medications. According to research, about a third of young people studied obtained pills from their own prescription (i.e., an unfinished prescription used outside of a physician's supervision), and 83 percent of adolescents had unsupervised access to their prescription medications. It is important for parents to understand the possible hazard of having misused prescription medications in their households. Parents should also understand the importance of proper storage and disposal of medications, even if they believe their child would not engage in non-medical use or diversion of prescription medications.

What Are Signs of Opioid Use?

According to the National Council on Alcoholism and Drug Dependence, 12 percent of male athletes and 8 percent of female athletes had used prescription opioids in the 12-month period studied. In the early stages of abuse, the athlete may exhibit unprovoked nausea and/or vomiting. However, as he or she develops a tolerance to the drug, those signs will diminish. Constipation is not uncommon, but may not be reported. One of the most significant indications of a possible opioid addiction is an athlete's decrease in academic or athletic performance, or a lack of interest in his or her sport. If these warning signs are noticed, best practices call for the student to be referred to the appropriate professional for screening, such as provided through an evidence-based practice to identify problematic use, abuse and dependence on illicit drugs (e.g., Screening, Brief Intervention, and Referral to Treatment [SBIRT]) offered through the New Jersey Department of Health.

What Are Some Ways Opioid Use and Misuse Can Be Prevented?

According to the New Jersey State Interscholastic Athletic Association (NJSIAA) Sports Medicine Advisory Committee, the following are recommendations to prevent misuse of opioid medications among student-athletes:

- The coach, athletic trainer, and any other approved medical professionals should follow the following:
  - The athlete should be educated about the importance of prescription opioids, properly disposing of unused medications, and never sharing them.
  - The athlete should be educated about the dangers of mixing prescription opioids with other medications or alcohol.

- Athletes and coaches should be trained in basic first aid and CPR.

- Athletes and coaches should be educated about the dangers of using prescription opioids and the importance of safe disposal.

- Athletes and coaches should be educated about the importance of proper storage of prescription opioids.

- Athletes and coaches should be educated about the dangers of driving while under the influence of prescription opioids.

- Athletes and coaches should be educated about the importance of seeking help if they suspect someone is using prescription opioids.

According to the NJSIAA Sports Medicine Advisory Committee chair, John P. August, D.O., "Studies indicate that more than 85 percent of heroin users started out by abusing prescription painkillers."
## Even With Proper Training and Prevention, Sports Injuries May Occur

There are two kinds of sports injuries. Acute injuries happen suddenly, such as a sprained ankle or strained back. Chronic injuries may happen after someone plays a sport or exercises over a long period of time, even when applying overuse-preventative techniques. 

Athletes should be encouraged to speak up about injuries, coaches should be supported in injury-prevention decisions, and parents and young athletes are encouraged to become better educated about sports safety.

### What Are Some Ways to Reduce the Risk of Injury?

Half of all sports medicine injuries in children and teens are from overuse. An overuse injury is damage to a bone, muscle, ligament, or tendon caused by repetitive stress without allowing time for the body to heal. Children and teens are at increased risk for overuse injuries because growing bones are less resilient to stress. Also, young athletes may not know that certain symptoms are signs of overuse.

The best way to deal with sports injuries is to keep them from happening in the first place. Here are some recommendations to consider:

- **PREPARE** Obtain the preparticipation physical evaluation prior to participation on a school-sponsored interscholastic or intramural athletic team or squad.
- **CONDITIONING** Maintain a good fitness level during the season and off-season. Also important are proper warm-up and cooldown exercises.
- **PLAY SMART** Try a variety of sports and consider specializing in one sport before late adolescence to help avoid overuse injuries.
- **ADEQUATE HYDRATION** Keep the body hydrated to help the heart more easily pump blood to muscles, which helps muscles work efficiently.
- **TRAINING** Increase weekly training time, mileage or repetitions no more than 10 percent per week. For example, if running 10 miles one week, increase to 11 miles the following week. Athletes should also cross-train and perform sport-specific drills in different ways, such as running in a swimming pool instead of only running on the road.
- **BEST UP** Take at least one day off per week from organized activity to recover physically and mentally. Athletes should take a combined three months off per year from a specific sport (may be divided throughout the year in one-month increments). Athletes may remain physically active during rest periods through alternative low-stress activities such as stretching, yoga or walking.
- **PROPER EQUIPMENT** Wear appropriate and properly fitted protective equipment such as pads (neck, shoulder, elbow, chest, knee, and shin), helmets, mouthpieces, face guards, protective cups, and eyewear. Do not assume that protective gear will prevent all injuries while performing more dangerous or risky activities.

### Resources for Parents and Students on Preventing Substance Misuse and Abuse

The following list provides some examples of resources:

- National Council on Alcoholism and Drug Dependence - NCA promotes addiction treatment and recovery.
- New Jersey Department of Health, Division of Mental Health and Addiction Services: is committed to providing consumers and families with a wellness and recovery-oriented model of care.
- New Jersey Prevention Network includes a parent guide on the effects of opioids.
- Operation Prevention Parent Toolkit is designed to help parents learn more about the opioid epidemic, recognize warning signs, and open lines of communication with their children and those in the community.
- Parent to Parent NJ is a nationwide network of families and friends struggling with alcohol and drug addiction.
- Partnership for a Drug-Free New Jersey: aiedo is an alliance created to localize and strengthen drug-prevention media efforts to prevent unlawful drug use, especially among youth.
- Teens for Teens: the voices of youth share common misperceptions about opioids through the voices of teens.

Youth Impacting NJ is made up of youth representatives from coalitions across the state of New Jersey who have been impacting their communities and peers by spreading the word about the dangers of underage drinking, marijuana use, and other substance misuse.

### References

| Massachusetts Technical Assistance Partnership for Prevention | American Academy of Pediatrics |
| New Jersey Statewide Multi-Tiered System of Supports | National Institute of Alcoholism and Drug Abuse |

An updated version of this fact sheet is available on the New Jersey Department of Education's Alcohol, Tobacco, and Other Drug Use webpage.