

2020-2021

## SPORTS REGISTRATION AND PERMISSION FORM

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Student ID# \_\_\_\_\_ School (As of Sept. 2020) \_\_\_\_\_

Grade (As of Sept. 2020)    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)

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**

**2020-2021**

**la parte I-forma de aprobación Paternal (para ser completado y firmado por padre)**

Nombre de Estudiante \_\_\_\_\_ Fecha \_\_\_\_\_

Dirección de Estudiante \_\_\_\_\_

Identificación Estudiante \_\_\_\_\_ Escuela \_\_\_\_\_

Grado (Apartir de Sept de 2019) 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 discapacidad permanente, parálisis, o muerte.

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

Firma de Padre/Guardiante: \_\_\_\_\_

Please  
Sign & Date

**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 supervisión ocasiones raras, estas lesiones pueden causar discapacidad 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: \_\_\_\_\_

Please  
Sign & Date



**Bartolomeo Candelino**  
**Director of Athletics**  
**Tel:(908)436-6689**  
**Fax:(908)436-6686**

2020-2021  
**PARENT NOTIFICATION**

**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.**



**Bartolomeo Candelino**  
**Director of Athletics**  
**Tel: (908) 436-6689**  
**Fax: (908) 436-6686**

## Requisitos de Examen Fisico Para Participacion en Deportes Escolares

**Estimados Padres/Guardiantes:**

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 deseando participar en equipos atleticos escolares deben devolver el cuestionario del distrito detallado Reporte de Examen Fisico, el cual incluye un revision complete y una medico de todos los sistemas del 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. Despues ser completado, debe llevarlo a la oficina de su medico de familia, quien para completer el exame 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 serán aceptados y serán devueltos a usted.

Después que se ha verificado que la información de los formularios es correcta, esta se presentara a nuestra junta medico. El doctor lo revisara y aprobará yo desaparoar la participación del estudiante.

Los padres / tutores serán 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 participará en ningun programa atletico hasta que este PROCESO HA SIDO COMPLETADO.



## 2020-2021 SPORTS PHYSICAL PACKET

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.

### **\*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.

2020-2021

**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 \_\_\_\_\_





## 2020-2021 Student -Athlete Code of Conduct

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:** \_\_\_\_\_



|                                                                                   |                           |                  |
|-----------------------------------------------------------------------------------|---------------------------|------------------|
|  | <b>MEDIA RELEASE FORM</b> | <b>2020-2021</b> |
|-----------------------------------------------------------------------------------|---------------------------|------------------|

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 autorizacion para que mi hijo/hija sea filmado o fotografiado por los medios de comunicacion como periodicos locales, el streaming de video o reporteros de la television que visitan nuestras escuelas de la Junta de Educacion. En ocasiones periodicos locales o reporteros de television visitan nuestras escuelas. Por medio de la presente doy mi permiso para que mi hiji/hija sea fotografiado o entrevistado por los medios de comunicacion y que las fotos y/o filmaciones puedan ser utilizadas por la television local, el streaming de video, o periodicos del area.

Tengo entendido que mi hijo/hija no va a ser entrevistado por ningun reporter de television o prensa local en la propiedad de la Junta de Educacion sin mi consenimeinto.

Please check one response:  
 (Por favor marque una respuesta:) YES (Si) ☐ 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)





**2020-2021**



## **Sports-Related Concussion and Head Injury Fact Sheet and Parent/Guardian Acknowledgement Form**

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 foggiess
- 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 too 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.

For further information on Sports-Related Concussions and other Head Injuries, please visit:

[www.cdc.gov/concussion/sports/index.html](http://www.cdc.gov/concussion/sports/index.html) [www.nfhs.com](http://www.nfhs.com) /[www.ncaa.org/health-safety/](http://www.ncaa.org/health-safety/) [www.bianj.org](http://www.bianj.org)  
[www.atsnj.org](http://www.atsnj.org)

Signature of Student-Athlete

Print Student-Athlete's Name

Date

Signature of Parent/Guardian

Print Parent/Guardian's Name

Date

*NJSIAA*



**COMPLETE THIS PAGE FOR HIGH SCHOOL ATHLETES ONLY!**

## **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



# ■ PREPARTICIPATION PHYSICAL EVALUATION THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam \_\_\_\_\_  
Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
Sex \_\_\_\_\_ Age \_\_\_\_\_ 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 prosthetic?                                          |  |  |  |
| 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                                  |  |  |  |
| Late 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 \_\_\_\_\_

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New Jersey Department of Education 2014; Pursuant to P.L. 2013, c. 123

THIS PAGE MUST BE COMPLETED BY PARENTS OF ALL ATHLETES EVEN IF THERE ARE NO SPECIAL NEEDS!!!

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



# ■ 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 \_\_\_\_\_ Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
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

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.

- Has a doctor ever denied or restricted your participation in sports for any reason?
- Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections  
Other: \_\_\_\_\_
- Have you ever spent the night in the hospital?
- Have you ever had surgery?
- Have you ever passed out or nearly passed out DURING or AFTER exercise?
- Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
- Does your heart ever race or skip beats (irregular beats) during exercise?
- Has a doctor ever told you that you have any heart problems? If so, check all that apply:  
☐ High blood pressure ☐ A heart murmur  
☐ High cholesterol ☐ A heart infection  
☐ Kawasaki disease Other: \_\_\_\_\_
- Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)
- Do you get lightheaded or feel more short of breath than expected during exercise?
- Have you ever had an unexplained seizure?
- Do you get more tired or short of breath more quickly than your friends during exercise?
- Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?
- Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?
- Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?
- Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?
- Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?
- Have you ever had any broken or fractured bones or dislocated joints?
- Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?
- Have you ever had a stress fracture?
- Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)
- Do you regularly use a brace, orthotics, or other assistive device?
- Do you have a bone, muscle, or joint injury that bothers you?
- Do any of your joints become painful, swollen, feel warm, or look red?
- Do you have any history of juvenile arthritis or connective tissue disease?

- Do you cough, wheeze, or have difficulty breathing during or after exercise?
- Have you ever used an inhaler or taken asthma medicine?
- Is there anyone in your family who has asthma?
- Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?
- Do you have groin pain or a painful bulge or hernia in the groin area?
- Have you had infectious mononucleosis (mono) within the last month?
- Do you have any rashes, pressure sores, or other skin problems?
- Have you had a herpes or MRSA skin infection?
- Have you ever had a head injury or concussion?
- Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?
- Do you have a history of seizure disorder?
- Do you have headaches with exercise?
- Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?
- Have you ever been unable to move your arms or legs after being hit or falling?
- Have you ever become ill while exercising in the heat?
- Do you get frequent muscle cramps when exercising?
- Do you or someone in your family have sickle cell trait or disease?
- Have you had any problems with your eyes or vision?
- Have you had any eye injuries?
- Do you wear glasses or contact lenses?
- Do you wear protective eyewear, such as goggles or a face shield?
- Do you worry about your weight?
- Are you trying to or has anyone recommended that you gain or lose weight?
- Are you on a special diet or do you avoid certain types of foods?
- Have you ever had an eating disorder?
- Do you have any concerns that you would like to discuss with a doctor?
- Have you ever had a menstrual period?
- How old were you when you had your first menstrual period?
- How many periods have you had in the last 12 months?

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 \_\_\_\_\_

# EVALUACIÓN FÍSICA – PRE-PARTICIPACIÓN

## FORMULARIO DE HISTORIAL MÉDICO

(Nota: Este formulario debe ser relleno por el paciente y padre/madre antes de ver al doctor. El doctor debe mantener este formulario en el expediente)

Fecha del examen \_\_\_\_\_

Nombre \_\_\_\_\_

Fecha de nacimiento \_\_\_\_\_

Sexo \_\_\_\_\_ Edad \_\_\_\_\_ Grado \_\_\_\_\_ Escuela \_\_\_\_\_ Deporte(s) \_\_\_\_\_

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

Tienes alergias ☐ Sí ☐ No Si la respuesta es sí, por favor identifica abajo la alergia específica.

☐ Medicamentos

☐ Polen

☐ Comida

☐ Picaduras de insecto

Explica abajo las preguntas respondidas con un "sí". Pon un círculo alrededor de las preguntas cuyas respuestas desconoces.

| PREGUNTAS GENERALES                                                                                                                                                                                                                                                                                                                                                                                       | Sí | No |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|----|
| 1. ¿Alguna vez un doctor te ha prohibido o limitado tu participación en deportes por alguna razón?                                                                                                                                                                                                                                                                                                        |    |    |
| 2. ¿Tienes actualmente alguna condición médica? Si es así, por favor identifícala abajo:<br><input type="checkbox"/> Asma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes<br><input type="checkbox"/> Infecciones<br>Otro: _____                                                                                                                                                        |    |    |
| 3. ¿Has sido ingresado alguna vez en el hospital?                                                                                                                                                                                                                                                                                                                                                         |    |    |
| 4. ¿Has tenido cirugía alguna vez?                                                                                                                                                                                                                                                                                                                                                                        |    |    |
| PREGUNTAS SOBRE LA SALUD DE TU CORAZÓN                                                                                                                                                                                                                                                                                                                                                                    | Sí | No |
| 5. ¿Te has desmayado alguna vez o casi te has desmayado DURANTE o DESPUÉS de hacer ejercicio?                                                                                                                                                                                                                                                                                                             |    |    |
| 6. ¿Has tenido alguna vez molestias, dolor o presión en el pecho cuando haces ejercicio?                                                                                                                                                                                                                                                                                                                  |    |    |
| 7. ¿Alguna vez has sentido que tu corazón se acelera o tiene latidos irregulares cuando haces ejercicio?                                                                                                                                                                                                                                                                                                  |    |    |
| 8. ¿Te ha dicho alguna vez un doctor que tienes un problema de corazón? Si es así, marca el que sea pertinente<br><input type="checkbox"/> Presión alta <input type="checkbox"/> Un soplo en el corazón<br><input type="checkbox"/> Nivel alto de colesterol <input type="checkbox"/> Una infección en el corazón<br><input type="checkbox"/> Enfermedad de Kawasaki <input type="checkbox"/> Otro: _____ |    |    |
| 9. ¿Alguna vez un doctor te ha pedido que te hagas pruebas de corazón? (Por ejemplo, ECG/EKG, ecocardiograma)                                                                                                                                                                                                                                                                                             |    |    |
| 10. ¿Te sientes mareado o te falta el aire más de lo esperado cuando haces ejercicio?                                                                                                                                                                                                                                                                                                                     |    |    |
| 11. ¿Has tenido alguna vez una convulsión inexplicable?                                                                                                                                                                                                                                                                                                                                                   |    |    |
| 12. ¿Te cansas más o te falta el aire con más rapidez que a tus amigos cuando haces ejercicio?                                                                                                                                                                                                                                                                                                            |    |    |

| PREGUNTAS SOBRE LA SALUD DEL CORAZÓN DE TU FAMILIA                                                                                                                                                                                                             | Sí | No |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|----|
| 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)? |    |    |
| 14. ¿Sufre alguien en tu familia de cardiomiopatía hipertrófica, síndrome Marfan, cardiomiopatía arritmogénica ventricular derecha, síndrome de QT corto, síndrome de Brugada, o taquicardia ventricular polimórfica catecolaminérgica?                        |    |    |
| 15. ¿Alguien en tu familia tiene problemas de corazón, un marcapasos o un desfibrilador implantado en su corazón?                                                                                                                                              |    |    |
| 16. ¿Ha sufrido alguien en tu familia un desmayo inexplicable, convulsiones inexplicables, o casi se ha ahogado?                                                                                                                                               |    |    |
| PREGUNTAS SOBRE HUESOS Y ARTICULACIONES                                                                                                                                                                                                                        | Sí | No |
| 17. ¿Alguna vez has perdido un entrenamiento o partido porque te habías lesionado un hueso, músculo, ligamento o tendón?                                                                                                                                       |    |    |
| 18. ¿Te has roto o fracturado alguna vez un hueso o dislocado una articulación?                                                                                                                                                                                |    |    |
| 19. ¿Has sufrido alguna vez una lesión que haya requerido radiografías, resonancia (MRI) tomografía, inyecciones, terapia, un soporte ortopédico/tabla, un yeso, o muletas?                                                                                    |    |    |
| 20. ¿Has sufrido alguna vez una fractura por estrés?                                                                                                                                                                                                           |    |    |
| 21. ¿Te han dicho alguna vez que tienes o has tenido una radiografía para diagnosticar inestabilidad del cuello o inestabilidad atlantoaxial? (Síndrome de Down o enanismo)                                                                                    |    |    |
| 22. ¿Usas regularmente una tabla/soporte ortopédico, ortesis, u otro dispositivo de asistencia?                                                                                                                                                                |    |    |
| 23. ¿Tienes una lesión en un hueso, músculo o articulación que te esté molestando?                                                                                                                                                                             |    |    |
| 24. ¿Algunas de tus articulaciones se vuelven dolorosas, inflamadas, se sienten calientes, o se ven enrojecidas?                                                                                                                                               |    |    |
| 25. ¿Tienes historial de artritis juvenil o enfermedad del tejido conectivo?                                                                                                                                                                                   |    |    |

(Por favor, continúe)





# PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

## PHYSICIAN REMINDERS

- 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 elsewhere?
  - 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 steroids or used any other performance enhancement?
  - 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 handrails?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

PLEASE FILL IN ALL AREAS

MARKED WITH AN ASTERISK \*

| Height                                                                                                                                                                                       | Weight | Sex        | Age   | Corrected |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|------------|-------|-----------|
| BP                                                                                                                                                                                           | Pulse  | Volm R.20/ | L.20/ | Corrected |
| <b>Appearance</b><br>* Marfan stigmata (cystic medial degeneration, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) |        |            |       |           |
| <b>Eyes/ears/nose/throat</b><br>* Pupils equal<br>* Hearing                                                                                                                                  |        |            |       |           |
| <b>Lymph nodes</b>                                                                                                                                                                           |        |            |       |           |
| <b>Heart*</b><br>* Murmurs (auscultation standing, supine, +/- Valsalva)<br>* Location of point of maximal impulse (PMI)                                                                     |        |            |       |           |
| <b>Palms</b><br>* Simultaneous femoral and radial pulses                                                                                                                                     |        |            |       |           |
| <b>Lungs</b>                                                                                                                                                                                 |        |            |       |           |
| <b>Abdomen</b>                                                                                                                                                                               |        |            |       |           |
| <b>Genitourinary (males only)</b>                                                                                                                                                            |        |            |       |           |
| <b>Skin</b><br>* HEN, lesions suggestive of MRSA, tinea corporis                                                                                                                             |        |            |       |           |
| <b>Neurologic*</b>                                                                                                                                                                           |        |            |       |           |
| <b>Neck</b>                                                                                                                                                                                  |        |            |       |           |
| <b>Back</b>                                                                                                                                                                                  |        |            |       |           |
| <b>Shoulders</b>                                                                                                                                                                             |        |            |       |           |
| <b>Elbows/Forearm</b>                                                                                                                                                                        |        |            |       |           |
| <b>Wrist/hand/fingers</b>                                                                                                                                                                    |        |            |       |           |
| <b>Hip/leg</b>                                                                                                                                                                               |        |            |       |           |
| <b>Feet</b>                                                                                                                                                                                  |        |            |       |           |
| <b>Legs/knees</b>                                                                                                                                                                            |        |            |       |           |
| <b>Functional</b><br>* Single-leg hop                                                                                                                                                        |        |            |       |           |

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
 \*Consider (SI) exam if in patient 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 \_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other information \_\_\_\_\_

### 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 \_\_\_\_\_

# Asthma Treatment Plan - Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.6) (Physician's Orders)



Asthma Condition  
New Jersey  
Our Pathway to Asthma Control  
2020-2021  
www.psmj.org



2020-2021

(Please Print)

|        |                                 |                   |
|--------|---------------------------------|-------------------|
| Name   | Date of Birth                   | Effective Date    |
| Doctor | Parent/Guardian (if applicable) | Emergency Contact |
| Phone  | Phone                           | Phone             |

## HEALTHY (Green Zone) |||||



You have **all** of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" - use if directed.

| MEDICINE                                                                                                                                            | HOW MUCH to take and HOW OFTEN to take it                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Advair® HFA <input type="checkbox"/> 45, <input type="checkbox"/> 115, <input type="checkbox"/> 230                        | 2 puffs twice a day                                                                                                                      |
| <input type="checkbox"/> Aerospir™                                                                                                                  | <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day                                                                 |
| <input type="checkbox"/> Alvesco® <input type="checkbox"/> 80, <input type="checkbox"/> 160                                                         | <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day                                                                 |
| <input type="checkbox"/> Dulera® <input type="checkbox"/> 100, <input type="checkbox"/> 200                                                         | 2 puffs twice a day                                                                                                                      |
| <input type="checkbox"/> Flovent® <input type="checkbox"/> 44, <input type="checkbox"/> 110, <input type="checkbox"/> 220                           | 2 puffs twice a day                                                                                                                      |
| <input type="checkbox"/> Qvar® <input type="checkbox"/> 40, <input type="checkbox"/> 80                                                             | <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day                                                                 |
| <input type="checkbox"/> Symbicort® <input type="checkbox"/> 80, <input type="checkbox"/> 160                                                       | <input type="checkbox"/> 1, <input type="checkbox"/> 2 puffs twice a day                                                                 |
| <input type="checkbox"/> Advair Diskus® <input type="checkbox"/> 100, <input type="checkbox"/> 250, <input type="checkbox"/> 500                    | 1 inhalation twice a day                                                                                                                 |
| <input type="checkbox"/> Asmanex® Twisthaler® <input type="checkbox"/> 110, <input type="checkbox"/> 220                                            | <input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day |
| <input type="checkbox"/> Flovent® Diskus® <input type="checkbox"/> 50 <input type="checkbox"/> 100 <input type="checkbox"/> 250                     | 1 inhalation twice a day                                                                                                                 |
| <input type="checkbox"/> Pulmicort Flexhaler® <input type="checkbox"/> 90, <input type="checkbox"/> 180                                             | <input type="checkbox"/> 1, <input type="checkbox"/> 2 inhalations <input type="checkbox"/> once or <input type="checkbox"/> twice a day |
| <input type="checkbox"/> Pulmicort Respules® (Budesonide) <input type="checkbox"/> 0.25, <input type="checkbox"/> 0.5, <input type="checkbox"/> 1.0 | 1 unit nebulized <input type="checkbox"/> once or <input type="checkbox"/> twice a day                                                   |
| <input type="checkbox"/> Singulair® (Montelukast) <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 10 mg            | 1 tablet daily                                                                                                                           |
| <input type="checkbox"/> Other                                                                                                                      |                                                                                                                                          |
| <input type="checkbox"/> None                                                                                                                       |                                                                                                                                          |

## Triggers

Check all items that trigger patient's asthma:

- ☐ Cold/flu
- ☐ Exercise
- ☐ Allergens
  - Dust Mites, dust, stuffed animals, carpet
  - Pollen - trees, grass, weeds
  - Mold
  - Pets - animal dander
  - Pests - rodents, cockroaches
- ☐ Odors (Irritants)
  - Cigarette smoke & second hand smoke
  - Perfumes, cleaning products, scented products
  - Smoke from burning wood, inside or outside
- ☐ Weather
  - Sudden temperature change
  - Extreme weather - hot and cold
  - Ozone alert days

nd/or Peak flow above \_\_\_\_\_

If exercise triggers your asthma, take \_\_\_\_\_ puff(s) \_\_\_\_\_ minutes before exercise.

Remember to rinse your mouth after taking inhaled medicine.

## CAUTION (Yellow Zone) |||||



You have **any** of these:

- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: \_\_\_\_\_

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

| MEDICINE                                                                                                                                        | HOW MUCH to take and HOW OFTEN to take it |
|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)                                                                    | 2 puffs every 4 hours as needed           |
| <input type="checkbox"/> Xopenex®                                                                                                               | 2 puffs every 4 hours as needed           |
| <input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg                                               | 1 unit nebulized every 4 hours as needed  |
| <input type="checkbox"/> Duoneb®                                                                                                                | 1 unit nebulized every 4 hours as needed  |
| <input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg | 1 unit nebulized every 4 hours as needed  |
| <input type="checkbox"/> Combivent RespiMat®                                                                                                    | 1 inhalation 4 times a day                |
| <input type="checkbox"/> Increase the dose of, or add:                                                                                          |                                           |
| <input type="checkbox"/> Other                                                                                                                  |                                           |

If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.

Quick-relief medicine does not help within 10 minutes or has been used more than \_\_\_\_\_ times and symptoms persist, call your doctor or go to the emergency room.

nd/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: \_\_\_\_\_

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

| MEDICINE                                                                                                                                        | HOW MUCH to take and HOW OFTEN to take it |
|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Albuterol MDI (Pro-air® or Proventil® or Ventolin®)                                                                    | 4 puffs every 20 minutes                  |
| <input type="checkbox"/> Xopenex®                                                                                                               | 4 puffs every 20 minutes                  |
| <input type="checkbox"/> Albuterol <input type="checkbox"/> 1.25, <input type="checkbox"/> 2.5 mg                                               | 1 unit nebulized every 20 minutes         |
| <input type="checkbox"/> Duoneb®                                                                                                                | 1 unit nebulized every 20 minutes         |
| <input type="checkbox"/> Xopenex® (Levalbuterol) <input type="checkbox"/> 0.31, <input type="checkbox"/> 0.63, <input type="checkbox"/> 1.25 mg | 1 unit nebulized every 20 minutes         |
| <input type="checkbox"/> Combivent RespiMat®                                                                                                    | 1 inhalation 4 times a day                |
| <input type="checkbox"/> Other                                                                                                                  |                                           |

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

Permission to Self-administer Medication:

- ☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.
- ☐ This student is not approved to self-medicate.

PHYSICIAN/AP/W/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.

- Parents/Guardians:** Before taking this form to your Health Care Provider, complete the top left section with:
  - Child's name
  - Child's doctor's name & phone number
  - Parent/Guardian's name & phone number
  - Child's date of birth
  - An Emergency Contact person's name & phone number
- Your Health Care Provider will complete the following areas:**
  - The effective date of this plan
  - The medicine 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
- 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
- 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:16-2.3. 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-administration of 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 \_\_\_\_\_

**The Pediatric/Adult  
Asthma Coalition  
of New Jersey**  
"Your Pathway to Asthma Control"  
PACNJ approved Plan available at  
[www.pacnj.org](http://www.pacnj.org)

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Sponsored by





**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



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



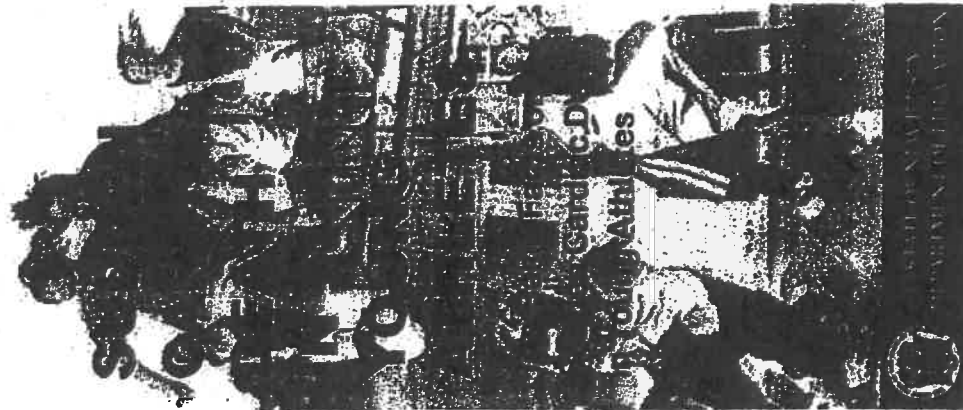
22

## Website Resources

- Sudden Death In Athletes  
<http://tinyurl.com/m2gJmVq>
- Hypertrophic Cardiomyopathy Association  
[www.4hcm.org](http://www.4hcm.org)
- American Heart Association [www.heart.org](http://www.heart.org)

## Collaborating Agencies:

- American Academy of Pediatrics**  
New Jersey Chapter  
3636 Quakerbridge Road, Suite 108  
Hamilton, NJ 08619  
(p) 609-842-0014  
(f) 609-842-0015  
[www.aapnj.org](http://www.aapnj.org)
- American Heart Association**  
1 Union Street, Suite 301  
Robbinsville, NJ, 08691  
(p) 609-208-0020  
[www.heart.org](http://www.heart.org)
- New Jersey Department of Education**  
PO Box 500  
Trenton, NJ 08625-0500  
(p) 609-292-5935  
[www.state.nj.us/education/](http://www.state.nj.us/education/)
- New Jersey Department of Health**  
P.O. Box 360  
Trenton, NJ 08625-0360  
(p) 609-292-7837  
[www.state.nj.us/health](http://www.state.nj.us/health)
- Lead Author: American Academy of Pediatrics,  
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NJ Academy of Family Practice, Pediatric Cardiologists,  
New Jersey State School Nurses  
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Louis Teichholz, MD; Perry Weinstock, MD



**American Academy of Pediatrics**  
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**S**udden 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 would you cardiac death in the young athlete?**

Sudden cardiac death is the result of an unexpected failure of proper heart function, usually (about 60% 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 (ven-TRICK-yo-lar fib-roo-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 (hi-per-TRO-fic CAR-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-it-al) (i.e., 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).

## SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

What are the current recommendations for screening young athletes?

- Myocarditis (myo-oh-car-DIE-tis), an acute inflammation of the heart muscle (usually due to a virus).
- Dilated cardiomyopathy, an enlargement of the heart for unknown reasons.
- Long QT syndrome and other electrical abnormalities of the heart which cause abnormal fast heart rhythms that can also run in families.
- Marfan syndrome, an inherited disorder that affects heart valves, walls of major arteries, eyes and the skeleton. It is generally seen in unusually tall athletes, especially if being tall is not common in other family members.

Are there warning signs to watch for?

- In more than a third of these sudden cardiac deaths, there were warning signs that were not reported or taken seriously. Warning signs are:
- Fainting, a seizure or convulsions during physical activity;
  - Fainting or a seizure from emotional excitement, emotional distress or being startled;
  - Dizziness or lightheadedness, especially during exertion;
  - Chest pains, at rest or during exertion;
  - Palpitations - awareness of the heart beating unusually (skipping, irregular or extra beats) during athletics or during cool down periods after athletic participation;
  - Fatigue or tiring more quickly than peers;
  - Being unable to keep up with friends due to shortness of breath (labored breathing).

expensive and are not currently advised by the American Academy of Pediatrics and the American College of Cardiology unless the PPE reveals an indication for these tests. In addition to the expense, other limitations of technology-based tests include the possibility of "false positives" which leads to unnecessary stress for the student and parent or guardian as well as unnecessary restriction from athletic participation.

The United States Department of Health and Human Services offers risk assessment options under the Surgeon General's Family History Initiative available at <http://www.hhs.gov/familyhistory/index.html>.

When should a student athlete see a heart specialist?

If the primary healthcare provider or school physician has concerns, a referral to a child heart specialist, a pediatric cardiologist, is recommended. This specialist will perform a more thorough evaluation, including an electrocardiogram (ECG), which is a graph of the electrical activity of the heart. An echocardiogram, which is an ultrasound test to allow for direct visualization of the heart structure, will likely also be done. The specialist may also order a treadmill exercise test and a monitor to enable a longer recording of the heart rhythm. None of the testing is invasive or uncomfortable.

Can sudden cardiac death be prevented just through proper screening?

A proper evaluation should find most, but not all, conditions that would cause sudden death in the athlete. This is because some diseases are difficult to uncover and may only develop later in life. Others can develop following a

infection of the heart muscle from a virus.

Trauma or other emergency situations and a family history of sudden cardiac death need to be performed on a yearly basis by the athlete's primary healthcare provider. With proper screening and evaluation, most cases can be identified and prevented.

Why have an AED on site during sporting events?

The only effective treatment for ventricular fibrillation is immediate use of an automated external defibrillator (AED). An AED can restore the heart back into a normal rhythm. An AED is also life-saving for ventricular fibrillation caused by a blow to the chest over the heart (commotio cordis).

N.J.S.A. 18A:40B-1.1 through 1.6, known as "Janet's Law", requires that at any school-sponsored athletic event or team practice in New Jersey public and nonpublic schools including any of grades K through 12, the following must be available:

- An AED in an unlocked location on school property within a reasonable proximity to the athletic field or gymnasium; and
  - A team coach, licensed athletic trainer, or other designated staff member if there is no coach or licensed athletic trainer present, certified in cardiopulmonary resuscitation (CPR) and the use of the AED; or
  - A State-certified emergency services provider or other certified first responder.
- The American Academy of Pediatrics recommends the AED should be placed in a central location that is accessible and ideally no more than 10 to 15 minutes walk from any sports facility. The AED should be made to activate 911 and emergency services while the AED is being used.

New Jersey requires all school athletes to be examined by their primary care physician at least once per year. The New Jersey Department of Education requires use of the specific Physical Education Physical Examination Form (PPE).

This process begins with the parents and student-athletes answering questions about symptoms during exercise (such as chest pain, dizziness, fainting, palpitations or shortness of breath), and questions about family health history.

The primary healthcare provider needs to know if any family member died suddenly during physical activity or during a seizure. They also need to know if anyone in the family under the age of 50 has had a sudden, unexplained sudden death, such as drowning or car accidents. This information must be provided annually to each team because it is so essential to identify those at risk for sudden cardiac death.

The required physical examination includes measurement of blood pressure and a careful listening examination of the heart, especially for murmurs and abnormal heartbeats. There are no warning signs reported on the health history or physical abnormalities discovered or recognized that prevent evaluation or testing its recommendations.

Are there options privately available to screen for cardiac conditions?

Technology exists for testing programs including individualized electrocardiogram (ECG) and echocardiogram. Echocardiogram, noninvasive ultrasound, options parents may consider in addition to the required



# 2018-19 NJSIAA Banned Drugs

**IT IS YOUR RESPONSIBILITY TO CHECK WITH THE APPROPRIATE OR DESIGNATED ATHLETICS STAFF BEFORE USING ANY SUBSTANCE**

The NJSIAA bans the following classes of drugs:

- Stimulants
- Anabolic Agents
- Alcohol and Beta Blockers
- Diuretics and Other Masking Agents
- Street Drugs
- Peptide Hormones and Analogues
- Anti-estrogens
- Beta-2 Agonists

**Note: Any substance chemically related to these classes is also banned.**

**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.**

## Drugs and Procedures Subject to Restrictions

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

## 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, including vitamins and minerals, 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.

**NOTE TO STUDENT-ATHLETES: THERE IS NO COMPLETE LIST OF BANNED SUBSTANCES. DO NOT RELY ON THIS LIST TO RULE OUT ANY SUPPLEMENT INGREDIENT. CHECK WITH YOUR ATHLETICS DEPARTMENT STAFF PRIOR TO USING A SUPPLEMENT. REMINDER: ANY DIETARY SUPPLEMENT INGREDIENT IS TAKEN AT THE STUDENT'S OWN RISK.**

**Some Examples of NJSIAA Banned Substances in Each Drug Class**  
**Do NOT RELY ON THIS LIST TO RULE OUT ANY LABEL INGREDIENT.**

**Stimulants**

Amphetamine (Adderall); caffeine (guarana); cocaine; ephedrine; fenfluramine (Fen); methamphetamine; methylphenidate (Ritalin); phentermine (Phen); synephrine (bitter orange); methylhexanamine, "bath salts" (mephedrone); Octopamine; DMBA; etc.

*exceptions:* phenylephrine and pseudoephedrine are not banned.

**Anabolic Agents** (sometimes listed as a chemical formula, such as 3,6,17-androstenetrione)  
Androstenedione; boldenone; clenbuterol; DHEA (7-Keto); epi-trenbolone; etiocholanolone; methasterone; methandienone; nandrolone; norandrostenedione; ostarine, stanozolol; stenbolone; testosterone; trenbolone; SARMS (ostarine); etc.

**Alcohol and Beta Blockers**

Alcohol; atenolol; metoprolol; nadolo; pindolol; propranolol; timolol; etc.

**Diuretics (water pills) and Other Masking Agents**

Bumetanide; chlorothiazide; furosemide; hydrochlorothiazide; probenecid; spironolactone (canrenone); triameterene; trichlormethiazide; etc.

**Street Drugs**

Heroin; marijuana; tetrahydrocannabinol (THC); synthetic cannabinoids (eg. spice, K2, JWH-018, JWH-073)

**Peptide Hormones and Analogues**

Growth hormone (hGH); human chorionic gonadotropin (hCG); erythropoietin (EPO); etc.

**Anti-Estrogens**

Anastrozole; tamoxifen; formestane; ATD, clomiphene; SERMS (nolvadex); etc.

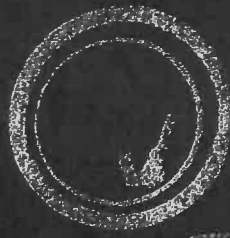
**Beta-2 Agonists**

Bambuterol; formoterol; salbutamol; salmeterol; higenamine; norcucurarine; etc.

**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



Each year, thousands of children and adolescents sustain eye injuries while participating in sports and recreational activities. The majority of these injuries are preventable. Parents and guardians can help protect their children's eyes by ensuring they wear appropriate protective eyewear when participating in sports and recreational activities.

### Prevention of Sports-Related Eye Injuries

Approximately 90% of sports-related eye injuries can be prevented with simple precautions, such as wearing protective eyewear.<sup>2</sup> 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 eye protectors. These should be made of polycarbonate lenses, a strong, shatterproof plastic. Polycarbonate lenses are much stronger than regular lenses.<sup>3</sup>

Health care providers (HCP), including family physicians, ophthalmologists, optometrists, and others, play a critical role in advising children, parents and guardians about the proper use

of protective eyewear. Find out what kind of eye protection is recommended, and permitted for each sport, visit the National Eye Institute at <http://www.nei.nih.gov/sports/findingprotection.asp>. Prevent Blindness America also offers tips on choosing and buying protective eyewear at <http://www.preventblindness.org/buying-sports-eye-protectors>, and <http://www.preventblindness.org/recommended-sports-eye-protectors>.

It is recommended that children participating in school sports or recreational sports wear protective eyewear. Parents and coaches need to make sure young athletes protect their eyes, and properly gear up for the game. Protective eyewear, like a uniform, is a must to help reduce the occurrence of sports-related eye injuries. Since many youth athletes do not wear eye protection, parents can help by ensuring that their children wear safety glasses or goggles. Parents can also set a good example by wearing protective eyewear when they play sports.

<sup>1</sup> National Eye Institute, National Eye Health Education Program, Sports-Related Eye Injuries: What You Need to Know and Tips for Prevention, [www.nei.nih.gov/sports/pdf/sportsrelatedeyeinjuries.pdf](http://www.nei.nih.gov/sports/pdf/sportsrelatedeyeinjuries.pdf), December 26, 2013.

<sup>2</sup> Rodriguez, Jorge O., D.O., and Lavina, Adrian M., M.D., Prevention and Treatment of Common Eye Injuries in Sports, <http://www.aafp.org/afp/2003/0401/p1481.html>, September 4, 2014; National Eye Health Education Program, Sports-Related Eye Injuries: What You Need to Know and Tips for Prevention, [www.nei.nih.gov/sports/pdf/sportsrelatedeyeinjuries.pdf](http://www.nei.nih.gov/sports/pdf/sportsrelatedeyeinjuries.pdf), December 26, 2013.

<sup>3</sup> Biederman, Troy, O.D., Sports Eye Injuries, [http://vision.about.com/od/emergencye/can\\_i/sports\\_injuries.htm](http://vision.about.com/od/emergencye/can_i/sports_injuries.htm), December 27, 2013.

## Most Common Types of Eye Injuries



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 a ball, a finger, a knee, or an elbow, sometimes cause a black eye or bruising (discoloring) in the area of the eye. More serious blunt injuries often bruise or 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 surface 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 a player is hit while they are being worn. Penetrating injuries must be treated quickly in order to preserve vision.

## Signs or Symptoms of an Eye Injury



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



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.

## Return to Play and Sports

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.

**Additional information on eye safety can be found at <http://isee.nei.nih.gov> and <http://www.nei.nih.gov/sports>.**

\*Bedinghaus, Troy, O.D., Sports Eye Injuries, [http://vision.about.com/od/emergencyeyecare/a/Sports\\_Injuries.htm](http://vision.about.com/od/emergencyeyecare/a/Sports_Injuries.htm), December 27, 2012.

# 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.<sup>1</sup> 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.<sup>2</sup>

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 previous prescriptions (i.e., an unfinished prescription used outside of a physician's supervision), and 83 percent of adolescents had unsupervised access to their prescription medications.<sup>3</sup> It is important for parents to understand the possible hazard of having unsecured 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.<sup>4</sup> 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,<sup>5</sup> 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).

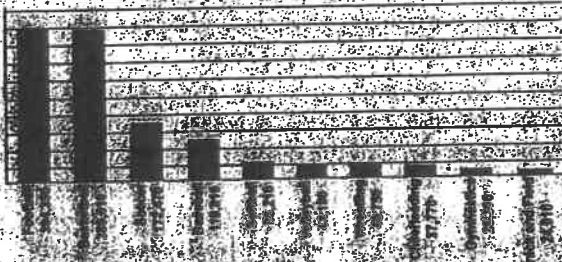
Adapted from: NJ State Sport  
Injury Prevention Committee  
Joint Report to the Governor  
and the Legislature  
on the Opioid Epidemic  
and its Impact on  
NJ's Youth





### Number of Injuries Nationally in 2012 Among Athletes 19 and Under from 10 Popular Sports

(Based on data from U.S. Consumer Product Safety Commission's National Electronic Injury Surveillance System)



SOURCE: USA TODAY, United Sports Survey of Emphasis, Youth Sports

## 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.

**PLAY SMART** Try a variety of sports and consider specializing in one sport before late adolescence to help avoid overuse injuries.

**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.

**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.

**CONDITIONING** Maintain a good fitness level during the season and offseason. Also important are proper warm-up and cooldown exercises.

**ADEQUATE HYDRATION** Keep the body hydrated to help the heart more easily pump blood to muscles, which helps muscles work efficiently.

**REST 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.

## 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 - NJ 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's quiz 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 grassroots coalition for families and children struggling with alcohol and drug addiction.

Partnership for a Drug Free New Jersey is New Jersey's anti-drug alliance created to localize and strengthen drug-prevention media efforts to prevent unlawful drug use, especially among young people.

The Science of Addiction: The Stories of Teens shares common misconceptions 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
- Centers for Disease Control and Prevention
- New Jersey State Interscholastic Athletic

Association (NJ SIAA) Sports Medical Advisory Committee (SMAC)

Athletic Management, David Csillan, athletic trainer, Ewing High School, NJ SIAA SMAC

National Institute of Arthritis and Musculoskeletal and Skin Diseases

USA TODAY

American Academy of Pediatrics

An online version of this fact sheet is available on the New Jersey Department of Education's Alcohol, Tobacco, and Other Drug Use webpage.  
Updated Jan. 30, 2018.