Long Valley Middle School 51 West Mill Road, Long Valley, New Jersey 07853

Mr. Mark Ippolito, Principal
Mrs. Danielle Schweitzer, Assistant Principal

Phone: 908-876-3434
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ATHLETIC PREPARTICIPATION PARENT LETTER & CHECK LIST

New Jersey State Law mandates that the school physician must clear all sports physicals prior to the start of each season. As such, **students will not be allowed to participate in interscholastic sports (including tryouts and practices)** until the school physician has cleared the student's sports physical. It is imperative that all paperwork is completed and returned in a timely manner to ensure approval and eligibility for participation. **All completed paperwork must be brought directly to the Long Valley Middle School.**

Listed below are the forms that need to be completed prior to the start of the sports season (signatures are required on all forms): Please read the forms carefully and use this checklist to ensure all the necessary forms are completed and signed.

PreParticipation Physical Evaluation Forms (Physical Forms):

☐1. HISTORY FORM - **must be attached to the physical examination and current within 365 days.**

- The entire form must be filled out.
- Any "yes" answers to questions 1-54 must be explained at bottom right of the form.
- The form must be **signed by the parent and athlete.**

☐2. PHYSICAL EXAMINATION FORM - **Physicals must be current within 365 days.**

- The Date of Exam must be filled in at the top of the physical and the physical must not expire before the start of the season.
- If the physical exam expires within a sport's season, the athlete will have two weeks to complete and return an updated physical for clearance.
- Height, Weight, Blood Pressure, Pulse, Review of Systems, and Clearance Level must be filled in by the physician.
- Vision must be completed and documented by the physician or an ophthalmologist's report must be attached.
- **Physicians must sign and stamp** the Physical Examination Form.

☐3. HEALTH HISTORY UPDATE - **Required prior to the start of each season.**

☐ 4. Athletic Sign-Off Sheet- **All four sections must be signed by parent and athlete.**
Educational Fact Sheets can all be found online.

☐ 5. Sports Permission Consent Sign-Off -**signed by parent and athlete** and **completed for EACH sport.**

☐ 6. **Additional forms** are required for students who have been diagnosed with Asthma (Asthma Action Plan), Life-Threatening Allergies (Anaphylaxis Action Plan), and other Medical Conditions; these forms are due yearly.

All sports forms are available on the **Long Valley Middle School Website** under the **For Students** tab, click on **Athletics**, and **Sports Forms**. *Asthma Action Plan* and *Anaphylaxis Action Plan* are located under the **For Parents** tab, then click on **District Forms**. If you have questions regarding the sports medical clearance process contact Mrs. Nancy Auld-Morogiello 908-876-3434 ext. 2306.

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 a 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.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. 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: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. 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)?		
14. 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?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. 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)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. 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 _____

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HE0503 9-7281A410

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

VISION MUST BE COMPLETED

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

Medical Provider Name: _____

Completed Cardiac Assessment Professional Development Module? ____Yes____No

Address Stamp:

Date of Physical: _____

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)†		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic‡		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
†Consider GU exam if in private setting. Having third party present is recommended.
‡Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

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 _____

Address _____ Phone _____

Signature of physician, APN, PA _____

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

(Optional)

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	

	Yes	No
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.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71 Revised Green Brook Family Medicine May 2014

New Jersey Department of Education
Health History Update Questionnaire

Name of School: _____

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student's parent or guardian.

Student: _____ Age: _____ Grade: _____

Date of Last Physical Examination: _____ Sport: _____

Since the last pre-participation physical examination, has your son/daughter:

1. Been medically advised not to participate in a sport? Yes ☐ No ☐
   If yes, describe in detail:
2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes ☐ No ☐
   If yes, explain in detail:
3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes ☐ No ☐
   If yes, describe in detail.
4. Fainted or "blacked out?" Yes ☐ No ☐
   If yes, was this during or immediately after exercise?
5. Experienced chest pains, shortness of breath or "racing heart?" Yes ☐ No ☐
   If yes, explain
6. Has there been a recent history of fatigue and unusual tiredness? Yes ☐ No ☐
7. Been hospitalized or had to go to the emergency room? Yes ☐ No ☐
   If yes, explain in detail
8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes ☐ No ☐
9. Started or stopped taking any over-the-counter or prescribed medications? Yes ☐ No ☐
10. Been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

    If diagnosed with Coronavirus (COVID-19), was your son/daughter symptomatic? Yes ☐ No ☐

    If diagnosed with Coronavirus (COVID-19), was your son/daughter hospitalized? Yes ☐ No ☐
11. Has any member of the student-athlete's household been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

Date: _____ Signature of parent/guardian: _____

Please Return Completed Form to the School Nurse's Office

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SPORTS/ELIGIBILITY PERMISSION CONSENT

Sign-Off Sheet

*****Please fill one form out for EACH sport*****

I, along with my son/daughter, whose signature appears below, acknowledge that we have read the Washington Twp. Schools Extracurricular Activities eligibility Policy and agree to adhere to all rules as outlined in the Policy.

I, along with my son/daughter, whose signature appears below, acknowledge the physical hazards that may be encountered in sports activities, and I give permission for him/her to try out for, _____ and be transported to and from any away competition(s).
(list one sport, a new form must be completed for EACH sport)

Student Signature:_____ **Print Student's Name:**_____

Parent or Guardian Signature: _____ **Print Parent or Guardian's Name:**_____

Date:_____

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Athletic Sign-Off Sheet

SPORTS-RELATED CONCUSSION AND HEAD INJURY FACT SHEET

N.J.S.A. 18A:40-41.2 requires public schools to distribute an annual educational fact sheet on sports-related concussion and head injury to the parents/guardians of students participating in interscholastic sports and cheerleading, and to obtain a signed receipt.
I/We have completely read and fully understand the provided information sheets for the parent and athlete. I understand the risks of playing a sport in addition to understanding the risks of continuing to play while recovering from a concussion. I (the athlete) agree to notify my coaches if I experience any of the symptoms listed on the concussion fact sheet prior to returning to participation.

Student Signature:_____ **Print Student's Name:**_____

Parent or Guardian Signature:_____ **Print Parent or Guardian's Name:**_____

USE AND MISUSE OF OPIOID DRUGS FACT SHEET

In accordance with N.J.S.A. 18A:40-41.10, public school districts participating in an interscholastic sports program must distribute the Opioid Use and Misuse Education Fact Sheet to all student-athletes and cheerleaders. In addition, school and district must obtain a signed acknowledgement of receipt of the fact sheet from each student-athlete and cheerleader and for students under age 18, the parent or guardian must also sign.
I/We acknowledge that we received and reviewed the *Educational Fact sheet on the Use and Misuse of Opioid Drugs.*

Student Signature:_____ **Print Student's Name:**_____

Parent or Guardian Signature:_____ **Print Parent or Guardian's Name:**_____

SPORTS-RELATED EYE INJURIES FACT SHEET

N.J.S.A. 18A: 40-41.9b requires this educational fact sheet on sports-related eye injuries to be distributed annually by each school district and nonpublic school to the parents/guardians of its student-athletes.
I/We acknowledge that we received and reviewed the Sports-Related Eye Injuries Fact Sheet.

Student Signature:_____ **Print Student's Name:**_____

Parent or Guardian Signature:_____ **Print Parent or Guardian's Name:**_____

SUDDEN CARDIAC DEATH PAMPHLET

This pamphlet must be distributed to each student-athlete and to the parents/guardians of the student-athletes, pursuant to N.J.S.A. 18A:40-41c-d.
I/We acknowledge that we received and reviewed the Sudden Cardiac Death in Young Athletes pamphlet.

Student Signature:_____ **Print Student's Name:**_____

Parent or Guardian Signature:_____ **Print Parent or Guardian's Name:**_____