RAMS

RESPECT + ATTITUDE + MATURITY = SUCCESS

2019 Winter Athletics Clearance Information

Step 1: Register on Family ID and/or Sign up for next sports season

To participate in Randolph Athletics, you need to register online on FamilyID. The link can be found at http://www.randolphathletics.rschoolteams.com/ under the tab for "sports registration". Once there, the link for Family ID is located under quick links. Please follow the prompts to create an account. Once you have an account or if you already have an account, click on 2019 Winter Athletics Registration and fill in the requested information. *Registration is required for each new sports season.*

Step 2: Medical Clearance BEFORE tryouts

You will need to have medical clearance before the start of tryouts/season. To be medically cleared you will need to have the entire 4 page **SPORTS PHYSICAL PACKET** or **RECHECK FORM** completed. These can be printed from the Athletics website (http://www.randolphathletics.rschoolteams.com/) Click on the sports registration tab and then choose PHYSICAL FORM and/or RECHECK FORM.

Sports Physical Form pages 1 & 2 are filled out and signed by the parent AND the student. Note: please fill out and sign page 2 even if it does not apply to you.

Sports Physical Form pages 3 & 4 are completed by your doctor or medical provider.

- If we currently have a sports physical on file for you and **the date of the actual exam was done AFTER November 11, 2018** you only need to give the nurse a Recheck Form that is filled out and signed by the parent **Please be aware that Recheck forms still need to be reviewed and cleared by the school doctor which can take 1-2 weeks.

- If we do not have a sports physical on file for you or **the date of your exam was BEFORE Nov 11, 2018**, you will need to have a new physical by your doctor and have your forms filled out and signed. Return to the Nurse before the **Nov 1st, 2019 deadline**. Recheck Form - parents, please fill out and sign as well.

THESE FORMS SHOULD BE COMPLETED & RETURNED TO THE NURSE'S OFFICE AT THE HIGH SCHOOL

Please be aware **if you were excused from Physical Education** due to an injury, illness, or concussion, you will need to provide a doctor's note clearing you before you can be cleared to participate in tryouts.

If you have Asthma or require an EpiPen, please make sure you have an updated Asthma Action Plan or Emergency Health Care Plan on file for the **2019-20 school year**. The forms can be found on the athletic website with the other forms. You will **not** be cleared until we receive the updated healthcare plan.

Step 3: Concussion ImPact Testing must be completed

If you have not had Concussion ImPact baseline testing yet, it can be scheduled through your coach and the athletic training staff and must be completed before you may participate in your sport. This is completed once per school year by freshmen, juniors and previously untested student athletes.

Thank you for your anticipated cooperation and do not hesitate to contact us with any question or concerns. You can reach us during the school year 7:30 am - 2:30 pm at 973-361-2400

Ms. Dorothy Incledon Carlson, RN ext 6509 *Mrs. Janice Lade, RN ext 6510*

Registration on Family ID Opens Sept 15th, 2019

*****All Forms are due by Nov 1st, 2019*****

The School Doctor

will be offering

SPORTS PHYSICAL EXAMS

On Thursday, October 17th

7:30 AM – 1:30 PM

Please make an appointment with the school nurses at

973-361-2400 ext 6506

 → **Parent and Athlete MUST complete and sign.**

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 _____ Parent Phone # _____

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

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 a 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 your doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ Heart murmur ☐ High Cholesterol ☐ 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, 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, seizures, or near drowning?		
BONE AND JOINT QUESTIONS ABOUT YOU	**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 ad an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
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 _____

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

Date of Exam _____ Parent Phone # _____
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 ports 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 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 _____

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Date of Exam _____ Parent Phone # _____
Name _____ Date of Birth _____
Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

PHYSICIAN REMINDERS:
17. Consider additional questions on more sensitive issues
    - Do you feel stressed out or under a lot of pressure?
    - Do you ever feel sad, hopeless, depressed, or anxious?
    - Do you feel safe at your home or residence?
    - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
    - During the past 30 days did you use chewing tobacco, snuff, or dip?
    - Do you drink alcohol or use any other drugs?
    - Have you ever taken anabolic steroids or used any other performance supplement?
    - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
    - Do you wear a seat belt, use a helmet, and use condoms?
18. Consider reviewing questions on cardiovascular symptoms (question 5-14)

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected: ☐Yes ☐No		
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)[1]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[2]		
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
[1] Consider GU exam if in private setting. Having third party present is recommended
[2] 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 or type) _____ Date _____
Address _____ Phone _____
Signature of physician, APN, PA _____

PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Date of Exam _____ Parent Phone # _____

Name _____ Date of Birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

- ☐ 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:

_____

Notification regarding this student's participation in athletics is based solely on the health history and medical examination and results submitted by the examining nurse practitioner, or physician's assistant from the student's medical home. The medical report complies with the requirements of NJAC6A: 16-2-2, http://www.state.nj.us/education/news/2002/medical.htm.

Physician's/Provider's Stamp

Office #: _____

Date of Exam: _____

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 or type) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Signature: _____ Date _____

State of 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____
   If yes, name of medication(s) _____

Date:_____ **Signature of parent/guardian** _____

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE'S OFFICE

E14-00284