

PREPARTICIPATION PHYSICAL EXAMINATION

Name: _____ **Exam Date:** _____ **Age:** _____ **Date of Birth:** _____
Address: _____ **City/State/Zip:** _____ **Home Phone:** _____
School: _____ **Sport:** _____ **Grade:** _____ **Sex:** _____
Physician: _____ **Phone:** _____ **Fax:** _____
Address: _____ **City/State/Zip:** _____

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH PAGES

Height: _____ **Weight:** _____ **Blood Pressure:** _____ / _____ **Pulse:** _____ bpm.
Vision: R 20/____ L 20/____ **Corrected:** Y / N **Contacts:** Y / N **Glasses:** Y / N

	Normal	Abnormal Findings	Comments
Head/Neck			
Eyes/Sclera/Pupils			
Ears			
Nose/Mouth/Throat			
Heart: Murmurs/Rhythms			
Lungs: Auscultation/Percussion			
Chest Contour			
Skin			
Abdomen: Assessment (inc. liver, spleen)			
Tanner Stage: Testes/Onset of Menses:			
Hernia	No	Yes/Possible	
Neck/Back/Spine: Range of Motion:			
Scoliosis:			
Upper Extremities			
Lower Extremities			
Neurological: Balance & Coordination:			
Romberg:			
Heel Walk:			
Tandem Walk:			
Nose Touch:			
Toe Walk:			
Most recent Immunizations/Dates:			
Medications currently in use:			
Additional Observations:			

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CLEARANCE:

- A. Student may participate in athletics: YES NO Date: _____
B. Cleared after completing evaluation/rehabilitation for: _____
C. **NOT CLEARED FOR:** Collision _____ Contact _____ Non-contact _____
Strenuous _____ Moderate _____ Non-strenuous _____
- Diagnosis: _____
Recommendations: _____

EXAMINED BY: Physician's/Provider's Stamp:

Family Physician/Provider _____
School Physician _____
____ MD ____ DO ____ NP ____ PA

Physician's/Provider's Signature: _____

SCHOOL PHYSICIAN'S NOTIFICATION

The school physician has received the medical report from the student's medical home and it complies with the requirements of *N.J.A.C. 6A:16-2.2(h)5*; and further, that the school physician's notification regarding the student's participation in athletics and signature is based solely on the medical examination and results submitted by the examining physician.

School Physician's Initials/Stamp: _____ Date: _____

CLASSIFICATION OF SPORTS BY CONTACT

<u>Collision/Contact</u>	<u>Limited Contact</u>	<u>Strenuous</u>	<u>Noncontact</u>	<u>Nonstrenuous</u>
Field Hockey	Baseball	Field		Bowling
Football	Basketball	Discus		Golf
Ice Hockey	Diving	Javelin		
Lacrosse	Fencing	Shot put		
Soccer	Field	Rowing		
Wrestling	High jump	Running/Cross Country		
	Pole vault	Strength Training		
	Gymnastics	Swimming		
	Skiing	Tennis		
	Softball	Track		
	Volleyball			

CONDITIONS REQUIRING CLEARANCE BEFORE SPORTS PARTICIPATION

- | | |
|--|----------------------------|
| Atlantoaxial instability | Bleeding disorder |
| Hypertension | Congenital heart disease |
| Dysrhythmia | Mitral valve prolapse |
| Heart murmur | Cerebral palsy |
| Diabetes mellitus | Eating disorders |
| Heat illness history | One-kidney athletes |
| Hepatomegaly, Splenomegaly | Malignancy |
| History of repeated concussion | Organ transplant recipient |
| Cystic fibrosis | Sickle cell disease |
| One-eyed athletes or athletes with vision > 20/40 in one eye | |