Important Information for the Physician Completing this Sports Physical

The State of New Jersey now requires that all physicians, advanced practice nurses (APN), or physicians assistants (PA) performing a sports physical examination, must complete the professional development module (PD module) prior to performing any sports physicals.

In order to expedite the clearance procedure of this athletic physical, please be sure and sign the bottom of the clearance form that you have completed the Cardiac Assessment Professional Development Module.

Thank you for your cooperation.
# Preparticipation Physical Evaluation 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.)

Name ___________________ Date of birth ________________

Sex _______ Age _________________ Grade __________________ School ____________________________________ Sport(s) ____________________

**History Form**

**Medicines and Allergies:** Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

<table>
<thead>
<tr>
<th>Medicines</th>
<th>Pollens</th>
<th>Food</th>
<th>Stinging Insects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>If yes, please identify specific allergy below.</td>
<td></td>
</tr>
</tbody>
</table>

Explain “Yes” answers below. Circle questions you don’t know the answers to.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever denied or restricted your participation in sports for any reason?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you have any ongoing medical conditions? If so, please identify below:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>Arthritis</td>
<td>Diabetes</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>A heart murmur</td>
<td>High cholesterol</td>
</tr>
<tr>
<td>3. Have you ever spent the night in the hospital?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>4. Have you ever had surgery?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5. Have you ever passed out or nearly passed out during or after exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7. Does your heart ever race or skip beats (irregular beats) during exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>9. Have you ever had an unexplained seizure?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>10. Do you get lightheaded or feel more short of breath than expected during exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>11. Have you ever had an unexplained heart murmur?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>12. Do you get more tired or short of breath more quickly than your friends during exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>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)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>14. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>15. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>16. Do you have any concerns that you would like to discuss with a doctor?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>18. Have you ever had any broken or fractured bones or dislocated joints?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>20. Have you ever had a stress fracture?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>21. Have you ever been told that you have or you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>22. Do you regularly use a brace, orthotics, or other assistive device?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>23. Do you have a bone, muscle, or joint injury that bothers you?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>24. Do any of your joints become painful, swollen, feel warm, or look red?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>25. Do you have any history of juvenile arthritis or connective tissue disease?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

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
# Preparticipation Physical Evaluation

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

| 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

<table>
<thead>
<tr>
<th>6. Do you regularly use a brace, assistive device, or prosthetic?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Do you use any special brace or assistive device for sports?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Do you have any rashes, pressure sores, or any other skin problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you have a visual impairment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Do you use any special devices for bowel or bladder function?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Have you had autonomic dysreflexia?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Do you have muscle spasticity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Explain “yes” answers here**

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

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

**Explain “yes” answers here**

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

Signature of athlete .................................. Signature of parent/guardian .................................. Date  


New Jersey Department of Education 2014; Pursuant to P.L. 2013, c. 71
NOTE: The pre-participation physical examination must be completed by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) has completed the Student-Athlete Cardiac Assessment Professional Development Module.

## Preparticipation Physical Evaluation

### Physical Examination Form

**Name** ___________________________ **Date of birth** ___________________________

### PHYSICIAN REMINDERS

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you used tobacco, alcohol, or other drugs?
   - Have you ever tried anabolic steroids or used any other performance supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

### Examination

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**BP** / ( ) / ( ) **Pulse**

**Vision R 20/20/20**

**BP** / ( ) / ( ) **Pulse**

**Vision L 20/20/20**

**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)

- Ey/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 pre-participation 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) ___________________________

Address ___________________________ Phone ___________________________

Signature of physician, APN, PA ___________________________


HE0503 9-2681/0410

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71
I have examined the above-named student and completed the pre-participation 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

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