

**RIDGEWOOD HIGH SCHOOL
MARCHING BAND**

SCHOOL PHYSICAL EXAMINATION PACKET

**THE FORMS INCLUDED IN THIS PACKET
MUST BE COMPLETED IN THEIR ENTIRETY
AND RETURNED TO THE
RHS SCHOOL NURSE ONLY.**

**DO NOT RETURN THESE FORMS TO AMEER
RIGHTHAND OR ANY BAND STAFF MEMBER.**

**PLEASE FOLLOW ALL INSTRUCTIONS
CAREFULLY AND OBSERVE DEADLINES.**

**STUDENTS WHO DO NOT SUBMIT THESE
FORMS ACCORDING TO THE GUIDELINES
MAY NOT BE PERMITTED TO PARTICIPATE.**

New Jersey Department of Education ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM - MARCHING BAND EDITION -

Part A: HEALTH HISTORY QUESTIONNAIRE - Completed by the parent & student and reviewed by examining provider

Part B: PHYSICAL EVALUATION FORM - Completed by examining licensed provider with MD, DO, APN or PA

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____ Date of Last Sports Physical: _____

Student's Name: _____ Sex: M F (circle one) Age: ____ Grade: _____

Date of Birth: ____/____/____ School: _____ District: _____

Sport(s): _____ Home Phone: (____) _____

Provider Name (Medical Home): _____ Phone: _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name of parent/guardian: _____ Relationship to student: _____

Phone (work): _____ Phone (home): _____ Phone (cell): _____

Additional emergency contact: _____ Relationship to student: _____

Phone (work): _____ Phone (home): _____ Phone (cell): _____

Directions: Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Have you ever had, or do you currently have:

- | | |
|--|---------------------------|
| a. Restriction from sports for a health related problem? | Y / N / Don't Know |
| b. An injury or illness since your last exam? | Y / N / Don't Know |
| c. A chronic or ongoing illness (such as diabetes or asthma)? | Y / N / Don't Know |
| (1.) An inhaler or other prescription medicine to control asthma? | Y / N / Don't Know |
| d. Any prescribed or over the counter medications that you take on a regular basis? | Y / N / Don't Know |
| e. Surgery, hospitalization or any emergency room visit(s)? | Y / N / Don't Know |
| f. Any allergies to medications? | Y / N / Don't Know |
| g. Any allergies to bee stings, pollen, latex or foods? | Y / N / Don't Know |
| (1.) If yes, check type of reaction: | |
| <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Breathing or other anaphylactic reaction | |
| (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) | Y / N / Don't Know |
| h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies, clotting disorders? | Y / N / Don't Know |
| i. A blood relative who died before age 50? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

List all medications here:

Medication Name	Dosage	Frequency

2. Have you ever had, or do you currently have, any of the following *head-related* conditions:

- | | |
|---|--------------------|
| a. Concussion or head injury (including "bell rung" or a "ding")? | Y / N / Don't Know |
| b. Memory loss? | Y / N / Don't Know |
| c. Knocked out? | Y / N / Don't Know |
| c. A seizure? | Y / N / Don't Know |
| d. Frequent or severe headaches (With or without exercise)? | Y / N / Don't Know |
| e. Fuzzy or blurry vision | Y / N / Don't Know |
| f. Sensitivity to light/noise | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

3. Have you ever had, or do you currently have, any of the following *heart-related* conditions:

- | | |
|---|--------------------|
| a. Restriction from sports for heart problems? | Y / N / Don't Know |
| b. Chest pain or discomfort? | Y / N / Don't Know |
| c. Heart murmur? | Y / N / Don't Know |
| d. High blood pressure? | Y / N / Don't Know |
| e. Elevated cholesterol level? | Y / N / Don't Know |
| f. Heart infection? | Y / N / Don't Know |
| g. Dizziness or passing out during or after exercise without known cause? | Y / N / Don't Know |
| h. Has a provider ever ordered a heart test (EKG, echocardiogram, stress test, Holter monitor)? | Y / N / Don't Know |
| i. Racing or skipped heartbeats? | Y / N / Don't Know |
| j. Unexplained difficulty breathing or fatigue during exercise? | Y / N / Don't Know |
| k. Any family member (blood relative): | |
| (1.) Under age 50 with a heart condition? | Y / N / Don't Know |
| (2.) With Marfan Syndrome? | Y / N / Don't Know |
| (3.) Died of a heart problem before age 50? If yes, at what age? _____ | Y / N / Don't Know |
| (4.) Died with no known reason? | Y / N / Don't Know |
| (5.) Died while exercising? If yes, was it during or after? (Circle one.) | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

4. Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat* conditions:

- | | |
|---|--------------------|
| a. Vision problems? | Y / N / Don't Know |
| (1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.) | Y / N / Don't Know |
| b. Hearing loss or problems? | Y / N / Don't Know |
| (1.) Wear hearing aides or implants? | Y / N / Don't Know |
| c. Nasal fractures or frequent nose bleeds? | Y / N / Don't Know |
| d. Wear braces, retainer or protective mouth gear? | Y / N / Don't Know |
| e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

5. Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic* conditions:

- | | |
|---|--------------------|
| a. Numbness, a "burner", "stinger" or pinched nerve? | Y / N / Don't Know |
| b. A sprain? | Y / N / Don't Know |
| c. A strain? | Y / N / Don't Know |
| d. Swelling or pain in muscles, tendons, bones or joints? | Y / N / Don't Know |
| e. Dislocated joint(s)? | Y / N / Don't Know |
| f. Upper or lower back pain? | Y / N / Don't Know |
| g. Fracture(s), stress fracture(s), or broken bone(s)? | Y / N / Don't Know |
| h. Do you wear any protective braces or equipment? | Y / N / Don't Know |

Explain all (yes) answers here (include relevant dates):

6. **Have you ever had or do you currently have any of the following general or exercise related conditions:**

- a. Difficulty breathing?
 - (1.) During exercise? Y / N / Don't Know
 - (2.) After running one mile? Y / N / Don't Know
 - (3.) Coughing, wheezing or shortness of breath in weather changes? Y / N / Don't Know
 - (4.) Exercise-induced asthma? Y / N / Don't Know
 - i. Controlled with medication? (specify _____) Y / N / Don't Know
 - ii. Experience dizziness, passing out or fainting? Y / N / Don't Know
- b. Viral infections (e.g. mono, hepatitis, coxsackie virus)? Y / N / Don't Know
- c. Become tired more quickly than others? Y / N / Don't Know
- d. Any of the following skin conditions:
 - (1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts? Y / N / Don't Know
 - (2.) Sun sensitivity? Y / N / Don't Know
- e. Weight gain/loss (of 10 pounds or more)? Y / N / Don't Know
 - (1.) Do you want to weigh more or less than you do now? Y / N / Don't Know
- f. Ever had feelings of depression? Y / N / Don't Know
- g. Heat-related problems (dehydration, dizziness, fatigue, headache)? Y / N / Don't Know
 - (1.) Heat exhaustion (cool, clammy, damp skin)? Y / N / Don't Know
 - (2.) Heat stroke (hot, red, dry skin)? Y / N / Don't Know
 - (3.) Muscle cramps? Y / N / Don't Know
- h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

7. **Females only:**

Age of onset of menstruation: _____ How many menstrual periods in the last twelve (12) months? _____
How many periods missed in the last twelve (12) months? _____

8. **Males only:**

Have you had any swelling or pain in your testicles or groin? Y / N / Don't Know

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Signature, Parent/Guardian or Student Age 18

Date of Signature:

THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.

ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

Part B: Physical Evaluation Form

(Completed by the examining licensed provider MD, DO, APN or PA)

- MARCHING BAND EDITION -

-STUDENT INFORMATION-

Student's Name: _____ Sport(s): Marching Band
 Sex: M F (circle one) Age: _____ Grade: _____ Date of Birth: _____
 Address: _____
 City/State/Zip: _____ Home Phone: _____
 School: _____ District: _____
 Parent/Guardian's Full Name: _____

- EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

If conducted by school physician check here

Name: _____ Phone: _____ Fax: _____

Address: _____ City/State/Zip: _____

- FINDINGS OF PHYSICAL EVALUATION -

Height: _____ Weight: _____ Blood Pressure: _____/_____/_____ Pulse: _____bpm.

Vision: R 20/____ L 20/____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it: Louder Softer No Change
		Squatting makes it: Louder Softer No Change
		Valsalva makes it: Louder Softer No Change
Femoral Pulses	YES	
Lungs: Auscultation/Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Assessment of physical maturation or Tanner Scale	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	
Hernia	ABSENT	
Evidence of Marfan Syndrome	ABSENT	

Most recent immunizations and dates administered:

Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Additional observations:

General Diagnosis:

General Recommendations:

THE HISTORY PREPARED BY THE PARENT/STUDENT MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE PHYSICAL EXAMINATION.

CLEARANCES: (See notes at bottom for conditions requiring attention and for a list of sports by level of contact)

- A. Student is cleared for participation in **all** sports without restriction.
- B. Student is **withheld clearance** for participation in any sport until evaluation / treatment of:

- C. Student is cleared for participation in **limited types** of sports which **exclude** the following types of sports contact: (CHECK ALL THAT APPLY)

CONTACT/COLLISION NON-CONTACT/STRENUOUS
 LIMITED CONTACT NON-CONTACT/NON-STRENUOUS

Due to: _____

HISTORY REVIEWED AND STUDENT EXAMINED BY:

Physician's/Provider's Stamp:

Primary Care Provider
School Physician Provider
License Type:

MD/DO
APN
PA

PHYSICIAN'S/PROVIDER'S SIGNATURE: _____ Today's Date: _____
Date of Exam: _____

HISTORY REVIEWED BY:

Name _____ Today's Date: _____
SIGNATURE: _____ Review Date: _____

RESERVED FOR SCHOOL DISTRICT USE

NOTES TO THE EXAMINING PROVIDER

Conditions requiring clearance before sports participation include, but are not limited to the following:

Anaphylaxis; 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; Seizure Disorder; Marfan Syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Basketball	Baseball	Discus	Bowling
Diving	Cheerleading	Javelin	Golf
Field Hockey	Fencing	Shot put	
Football	High Jump	Rowing	
Ice Hockey	Pole vault	Running/Cross Country	
Lacrosse	Gymnastics	Strength Training	
Soccer	Skiing	Swimming	
Wrestling	Softball	Tennis	
	Volleyball	Track	
	Color Guard/Winter Guard	Marching Band	

N.J.A.C. 6A:16-2.2 requires the school physician to provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this physical evaluation. This evaluation and the notification letter become part of the student's school health record.

Effects of physiologic maneuvers on heart sounds:

Standing	Increases murmur of HCM Decreases murmur of AS, MR MVP click occurs earlier in systole
Squatting	Increases murmur of AS, MR, AI Decreases murmur of MCH MVP click delayed
Valsalva	Increases murmur of HCM Decreases murmur of AS, MR MVP click occurs earlier in systole

HCM = Hypertrophic Cardio Myopathy
 AS = Aortic Stenosis
 AI = Aortic Insufficiency
 MR = Mitral Regurgitation
 MVP = Mitral Valve Prolapse

Physical Stigmata of Marfan's Syndrome

Kyphosis
 High arched palate
 Pectus excavatum
 Arachnodactyly
 Arm span > height 1.05:1 or greater
 Mitral Valve Prolapse
 Aortic Insufficiency
 Myopia
 Lenticular dislocation

RIDGEWOOD PUBLIC SCHOOLS

Ridgewood, New Jersey

School Health Services

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING:

MARCHING BAND PRESEASON TRAINING CAMP

(TO BE COMPLETED BY A PARENT/GUARDIAN)

Student Name _____

I request that my child be assisted in taking the medicine(s) described below during Marching Band Preseason Training Camp by authorized persons or be permitted to medicate self as also authorized by me and my physician under the supervision of the nurse. I relieve the Ridgewood Board of Education and its employees of any liability, which may result from the administration of medication to my child or from self-administration when certified by the physician.

Date	Parent/Guardian Signature	Home Phone	Cell Phone
------	---------------------------	------------	------------

PHYSICIAN AUTHORIZATION

Name of Medication _____

Dose: _____ Route: _____

Time: _____ Duration of Use: _____

Diagnosis (reason for medication) _____

Is child capable and instructed in self-administration? _____

Potentially life threatening condition for self-administration:

Possible side effects: _____

Emergency Intervention Protocol:
(Epipen, inhaler, insulin, glucagon, etc.) _____

Other Comments: _____

Date: _____ Physician's Signature _____

Physician's Name _____

Address _____

Telephone# _____

SCHOOL ATHLETIC / MARCHING BAND PHYSICALS

NOTE TO PARENTS AND EXAMINING PHYSICIANS:

All Athletic/Marching Band Physicals are due Friday August 14th, 2009

Physicals must be submitted in person before June 24 or on the dates below

The New Jersey Department of Education and the New Jersey State Interscholastic Athletic Association require the Pre-Participation Physical Examination Form for ALL student athletes. The Physical must have been performed after August 17, 2008. This form was developed by these organizations, not by Ridgewood High School.

The sport / activity needs to be indicated on the form.

The physical contains 2 parts. One portion must be completed by the parents, and one portion by the doctor/clinic.

The date of the physical is required to be on the paper.

All parts of the physical must be filled out in pen including pulse, blood pressure. If you answer "yes" to any question, there must be an explanation. Physicals must be submitted to The Health Services Office in person.

A vision test is part of the standard medical care for routine sports / marching band physicals. Please remind your doctor/clinic to do a vision screening. If your doctor/clinic does not do a vision screening, the school physician will not clear your child for sports / marching band.

The school nurse is **not** permitted to do a vision screening for a sports / marching band physical.

Participation in athletics / marching band is based on the results of your personal physician/clinic report and the school physician's clearance is based on that examination. This complies with the requirements of NJAC 6A:16-2.2

A Ridgewood High School Athletic Consent and Health Update form must be submitted for every sport.

August 2009						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3	4 ATHLETIC / MARCHING BAND PHYSICAL COLLECTION 9-2 PM	5 ATHLETIC / MARCHING BAND PHYSICAL COLLECTION 9-2 PM	6 ATHLETIC / MARCHING BAND PHYSICAL COLLECTION 9-2 PM	7 ATHLETIC / MARCHING BAND PHYSICAL COLLECTION 9-2 PM	8
9	10	11	12 ATHLETIC / MARCHING BAND PHYSICAL COLLECTION 9-2 PM	13 ATHLETIC / MARCHING BAND PHYSICAL COLLECTION 9-2 PM	14 ATHLETIC / MARCHING BAND PHYSICAL COLLECTION 9-2 PM	15
16	17 FALL SEASON STARTS	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

**RIDGEWOOD HIGH SCHOOL
SEASONAL HEALTH UPDATE AND ATHLETIC CONSENT
MARCHING BAND EDITION**

(To be completed by the parent and student)

For Office Use:
Athletic Office _____
Health Office _____

NAME OF STUDENT MARCHING BAND MEMBER/ATHLETE: _____

ATHLETIC SEASON (PLEASE CIRCLE ONE): **FALL** **WINTER** **SPRING**

SCHOOL YEAR _____ **GRADE** _____ **SPORT** Marching Band _____.

DATE OF LAST PHYSICAL _____

HEALTH UPDATE

A health update is required for **each athletic season** and must be completed and approved prior to participation in Marching Band or any athletic activity. Please provide a health update of medical problems, issues and/or concerns experienced since the last medical examination by answering the following questions. Additionally, please explain "yes" answers at the bottom of this section. You MUST respond to all questions.

SINCE YOUR LAST MEDICAL EXAMINATION: (please circle and explain if YES)

- | | | |
|--|------------|-----------|
| 1. Asthma | YES | NO |
| 2. Have you had any illnesses ,injuries, concussion, etc. | YES | NO |
| 3. Allergies requiring an Epinephrine auto-injector | YES | NO |
| 4. Have you taken/or are you currently taking any medications? | YES | NO |
| 5. Special Concerns (explain below) | YES | NO |

If you answered YES to any of the above, please explain:

PERMISSION/CONSENT

I/we attest that the information provided within the marching band/athletic physical examination, health history questionnaire and health update is accurate. I/we give permission for medical information to be shared with the school nurse, athletic trainer, and applicable coaches and advisors. In case of accident or serious illness and the school is unable to reach me, I hereby authorize the school to call my child's physician and to follow his/her instructions. If it is impossible to contact my child's physician, the school may contact any of the emergency contacts on record and make whatever medical arrangements are necessary. While the school attempts to contact the above persons, the school will provide immediate triage and contact emergency medical services/the rescue squad when deemed necessary.

I/we give permission for my/our child to participate in marching band/athletics (sport listed above) during this school year. I/we recognize that these activities involve the potential for injury, which is inherent in all sports or athletic activities. I/we acknowledge that even with the best coaching, use of the most advanced protective equipment, and the strict observance of rules, injuries are possible. On rare occasions, these injuries can be severe as to result in total disability, paralysis, or even death. I/we release the Ridgewood Board of Education and its employees from any claim stemming from participation in this interscholastic sports program. I/we give permission for travel to away contests by school bus, charter bus or other school arranged transportation.

MEDICATION CONSENT

As a parent/Legal guardian, I authorize the Registered Nurse to administer the following OTC medications to the above named student. Ibuprofen 200mg(1-2 tablets every 6 hours) Acetaminophen 325 mg (1-2 tablets every4-6 hours), Tums chewable antacid (1-2 tablets)

Parent/Guardian Signature: _____

Date: _____

Email Address _____

Student Signature: _____

Date: _____