COLLINGSWOOD PUBLIC SCHOOLS
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Special Education Medicaid Initiative (SEMI) Parental Consent Form
Collingswood Public Schools

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school district.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or insurance to pay for special education or related services under Part 300 (services under the IDEA).

I understand that billing for these services by the district does not impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, and loss of eligibility or impact on lifetime benefits.

Student's Name: _____

Student's Date of Birth: _____

Parent/Guardian Name: _____

I give consent to bill for SEMI: ____Yes ____No

This consent can be revoked at any time by contacting the administrator at your child's school.

Parent/Guardian Signature: _____ **Date:** _____

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Proof of Domicile

Student Name: _____ **Gr:** _____

Dear Parent/Guardian:

The Collingswood Board of Education has policies and procedures related to "Proof of Domicile" for students who attend our schools. The District shall only provide a free education to those students who are domiciled within the District or who otherwise qualify for a free education pursuant to the statutory and regulatory guidelines set forth in N.J.S.A. 18A:38-1 et seq. and N.J.A.C. 6A:22-1.1 et seq. A student shall be domiciled in the District "when he or she is living with a parent or legal guardian whose permanent home is located within the District." N.J.A.C. 6A:22-3.1 The home is permanent if "the parent or guardian intends to return to it when absent and has no present intent of moving from it..." Id. If the District discovers that a student is attending school whose parents are not domiciled within the District and who is not otherwise eligible for a free education, the District may apply for the student's removal and seek tuition reimbursement for the period of ineligible attendance in accordance with the provisions of the N.J.S.A. 18A:38-1(b)(2).

Applicants who fraudulently allow a child of another to use his residence, or who fraudulently claim to have custody of a child, may be charged with a disorderly persons offense. N.J.S.A. 18A:31-1(c). If the applicant is convicted of such an offense, the applicant may be fined up to $1,000.00 and/or be imprisoned for up to 6 months.

Any false statements, answers or declarations contained in the Affidavit or in an application for admission may subject the applicant to criminal prosecution for the crime of false swearing, in violation of N.J.S.A. 2C:43-3. If convicted for such a crime, the applicant may be punished by a fine of $10,000.00 and/or be imprisoned for up to 18 months.

I, the undersigned, hereby acknowledge that I have read and understood the contents of this notification.

Printed Name of Parent/Guardian: _____

Parent/Guardian Signature: _____

Date: _____

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Home Language Survey

Student's Name: _____ Date of Birth: _____ Gr: _____

Parent/Guardian Name: _____ Phone #: _____

As required by state and federal law (State Bilingual Education Act of 1974, Federal Lau vs. Nicholas Supreme Court ruling of 1974), all parents must be surveyed as to the home language of their public school children. The child's parent/guardian must complete the form.

This data is used to determine need for language support services. The district offers students English as a Second Language where appropriate and/or if desired by parents.

---

1. What language did your child learn when he/she first began to speak? _____
2. What language do you use most often when speaking to your child at home? _____
3. What language does your child use most often when speaking to you? _____
4. What language does your child use most when speaking to brothers and sisters? _____
5. What language does your child use most often when speaking to other relatives? _____
6. What language does your child use most often when speaking to friends at home? _____

Was your child born in the United States? (Please circle)

Yes No

If born outside of the United States, please list the Country of Birth and date entered into USA:

_____ _____
Country of Birth Date entered into USA

_____ _____
Parent/Guardian Signature Date

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Parent Authorization for Release of School Records

Name of school previously attended: _____

School Address: _____

School Phone Number: _____ School Fax Number: _____

Student Name	Date of Birth	Grade

In accordance with the New Jersey Administrative Code Inspection of School Records, the above-named school is hereby authorized to release to the school named below all school records, including NJ State ID #, grades, health, medical, psychological, social, educational, developmental and discipline records.

Request for Transcript of School Records

Please send all academic school records to the school selected below:

____ Collingswood High School
424 Collings Avenue
Collingswood, NJ 08108
856-962-5701

____ Collingswood Middle School
414 Collings Avenue
Collingswood, NJ 08108
856-962-5702

____ James A. Garfield School
480 Haddon Avenue
Collingswood, NJ 08108
856-962-5705

____ Mark Newbie School
2 East Browning Road
Collingswood, NJ 08108
856-962-5706

____ Thomas Sharp School
400 Comly Avenue
Collingswood, NJ 08107
856-962-5707

____ William P. Tatem School
265 Lincoln Avenue
Collingswood, NJ 08108
856-962-5704

____ Zane North School
801 Stokes Avenue
Collingswood, NJ 08108
856-962-5703

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

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GENESIS PARENT PORTAL

Our new Genesis Parent Portal is now open for all parents. Please complete this form and return it with your registration packet.

Thank you.

Please Print Clearly

Parent/Guardian Information
Parent/Guardian Name: _____ Relationship to student: _____ Telephone #: _____ Email: _____ I certify that I am the legal guardian of the student(s) listed below and wish to gain access to the Genesis Parent Portal. Parent/Guardian Signature: _____ Date: _____
Student(s) Information
Student Name: _____ Grade: _____ Date of Birth: _____
Student Name: _____ Grade: _____ Date of Birth: _____
Student Name: _____ Grade: _____ Date of Birth: _____
Student Name: _____ Grade: _____ Date of Birth: _____
Student Name: _____ Grade: _____ Date of Birth: _____

Student/Parent Pledge for Chromebook Use

I /we understand that Chromebooks are intended primarily for educational use and that students are not permitted to download any applications that use unnecessary memory and compromise the ability of the Chromebook to handle educational needs.

I/we understand it is my/our responsibility to understand and follow the values and standards of cyber safety that children should follow on the use of the Internet.

I/we understand my/our responsibilities with respect to the care and maintenance of the Chromebook.

I/we understand the terms and conditions of the insurance coverage for the Chromebook provided by the Collingswood School District.

I/we understand that students at the high school level may take Chromebooks home in the evenings for school related use; however, I/we understand that students must have Chromebooks in school every day.

I/we understand that students must return Chromebooks at the end of the school year in the condition it was received with the exception of normal wear. While the District may offer an option for students to keep the Chromebooks over the summer months, I/we understand that the Collingswood School District reserves the right to conduct unannounced inspections of student Chromebooks.

I/we understand that I must report any problems or damage to the Chromebook to the Technology Office.

I/we understand that the use of Chromebooks will be governed by all terms and conditions of the Collingswood School District policies and regulations, including but not limited to the Collingswood School District Use of Technology Policy 2361.

I/we understand that the technology device provided by the school district may record or collect information on the pupil's activity or the pupil's use of the technology device. The school district shall not use any of the capabilities in a manner that would violate the privacy rights of the pupil or any individual residing with the pupil. Reasons for collecting information include, but are not limited to: Tracking the theft or inappropriate use of the device; honoring a warrant from a local, county, state, or federal law enforcement agency; or, at the request of the student or parent of the student to whom the device was issued.

Individual school Chromebook computers and accessories must be returned to the Collingswood Schools at the end of each school year. Students who graduate early, withdraw, are suspended or expelled, or terminate enrollment at Collingswood Schools for any other reason must return their individual school Chromebook computer on the date of termination. Failure to hand in Chromebook under any of these circumstances will result in the withholding of student records.

I /We agree to the stipulations set forth in the above documents including the Chromebook Policy, Procedures, and Information; the Acceptable Use Policy; Chromebook Care Protection Plan and the Student Pledge for Chromebook Use.

Please Print Clearly:

Student Name (Last, First): _____ Grade: _____

Student Signature: _____ Date: _____

Parent Name (Please Print): _____

Parent Signature: _____ Date: _____

CHROMEBOOK POLICY & USAGE RECEIPT OF NOTIFICATION AND UNDERSTANDING

DUE BY: September 30th This School Year

Your signature indicates that you have read, understand, and agree to abide by the requirements of Collingswood Public Schools Student/Parent Pledge for Chromebook Use regarding the use of computers, including the Chromebook, and the Internet in the Collingswood Public Schools. Your signature also states that you authorize the Collingswood Public Schools to create and utilize "cloud services" accounts for your student that will be under the control of Collingswood Public Schools, but which reside elsewhere on the Internet. (Certain cloud services require parental permission for students regardless of the level of control over the account granted to CPS.)

Additionally, to participate in the 1:1 Chromebook initiative, the Collingswood Public Schools is requiring the purchase of a Chromebook Care, Repair and Replacement package. Students who purchase the Chromebook Care package will be permitted to take the Chromebook home. This form, with your signature and payment, must be completed prior to the deployment of the Chromebook to your child. Under this agreement, the Chromebooks are protected against accidental damage. The Collingswood Public Schools will require that a police report be submitted in cases of theft. Fraudulent reporting of theft will be turned over to the police for prosecution. A student making a false report will also be subject to disciplinary action as outlined by the school code of conduct.

This fee does not cover for loss of the Chromebook and/or its accessories, cosmetic damage, or damages caused by intentional misuse and abuse. The Collingswood Public Schools will assess the Chromebook damage and repair or replace the device if the damage is determined to be accidental and within the protection guidelines outlined below. **Parents/Students will be charged for full replacement cost of a device that has been lost or damaged due to intentional misuse or abuse.**

Annual Coverage: $35	
Accidental Damage Incidents #1 and #2	Accidental Damage Incident #3 or more
Total Replacement of Chromebook: $145 Replacing Screen: $50 Replacing Keyboard/Touchpad: $65 Replacing Power Cord: $17.50 Other parts/accessories not listed: 50% cost to district	Total Replacement of Chromebook: $290 Replacing Screen: $100 Replacing Keyboard/Touchpad: $130 Replacing Power Cord: $35 Other parts/accessories not listed: 100% cost to district

**Note: Each time a Chromebook is submitted for repair, the device will be examined for any additional damage. All damages will be repaired and all fees must be paid prior to the Chromebook being returned to the student.*

Please check one of the following options:

☐ I would like to purchase the Chromebook Care Plan through the Collingswood Public Schools in the amount of $35. Please note: $35 is an annual enrollment fee. Purchase of the Chromebook Care Plan is required for the student to take the Chromebook home from school.

☐ Rather than use a school device, I will purchase a **Chromebook** for my child for use in school. I would like my child to access district resources requiring the purchase of a license for a **one-time fee** of $32.50.

_____ _____

Print Student Name Here, Grade

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature (REQUIRED) Date

STUDENT-ATHLETE RESIDENCY AFFIDAVIT

NJSIAA STUDENT-ATHLETE RESIDENCY AFFIDAVIT

_____
Print Student Full Name

I, _____, of full age, being duly sworn to law, upon my oath depose and say:

1. I am the parent/legal guardian of the above listed student.

2. I currently reside at _____
   I have resided at the above address since: _____

3. The above-named student moved with me at my new address on _____

4. Prior to moving to the new residence address listed above, I resided at the following address: _____
   _____

5. I hereby authorize the New Jersey State Interscholastic Athletic Association ("NJSIAA") to investigate and confirm any and all Statements made by me in this affidavit. I agree to provide any additional information that may be requested by the NJSIAA.

6. I will notify the present school immediately, in writing, if any of the conditions recited herein are changed.

7. This residence may not be associated with, leased, or provided by anyone associated with the school or acting at the direction of the school, including but not limited to administration, staff, coaches, students, parents, booster clubs, or any organization having a connection with the school.

I hereby certify that the forgoing statements are true, and I am aware that if any of the foregoing statements are willfully false, I am subject to punishment.

_____ _____
Parent/Guardian Signature Print Parent/Guardian Full Name

STATE OF NEW JERSEY
COUNTY OF _____
The above-named affiant appeared before me, a notary public of the State of New Jersey, on the _____ day of _____, 20____, and I made known to him/her the contents of the above affidavit which was then sworn and subscribed to by said affiant before me on this date.

_____
NOTARY PUBLIC

Copies of this Affidavit will be sent to the New Jersey State Interscholastic Athletic Association upon request.

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Student Health Record

Student Name: _____ Gr. _____ D.O.B. _____ Gender: _____

Parent/Guardian Name: _____ Address: _____

Phone Number: _____ Email: _____

Child's Physician: _____ Phone Number: _____

Preferred Hospital: _____

1. Does your child have any of the following health concerns? Please check any of the following health concerns that your child has:

___ Life Threatening Allergy
___ Convulsive Disorder
___ Heart Disease
___ Food Allergy
___ Birth Defect
___ Attention Deficit Disorder
___ Congenital Defect
___ Hearing Problem
___ Non-Life Threatening Allergy
___ Diabetes
___ Lyme Disease
___ Food Restrictions
___ Mental Health
___ Tourette's Syndrome
___ Obsessive Compulsive Disorder
___ Other
___ Asthma
___ Headaches
___ Neuromuscular Disease
___ Seasonal Allergies
___ Gastrointestinal Disorder
___ Cancer
___ Vision Problem

Please explain all checked responses. Also, specify any reactions to allergies: _____

_____

2. Does your child have an Epi-pen with a doctor's order? ___ Yes ___ No (If Yes, please provide the doctor's order)

3. Does your child have an inhaler with a doctor's order? ___ Yes ___ No (If Yes, please provide the doctor's order)

4. Is your child taking any medication on a daily basis OR as needed? ___ Yes ___ No (If yes, please provide the name of the medication, dosage, frequency and reason): _____

_____

5. Has your child had any illnesses in the past year? (example: Chicken pox, Mumps, Measles, Mono) ___ Yes ___ No (If yes, reason and date of illness): _____

_____

6. Has your child had surgery or been hospitalized over the past year? ___ Yes ___ No (If yes, reason and date of hospital stay): _____

_____

7. Has your child broken any bones over the past year? ___ Yes ___ No (If yes, please specify which bone or body part and the date): _____

_____

8. Please list any serious injuries, surgery or medical conditions, with dates, your child has experienced.

_____

For the safety of your child, this medical information will be shared with staff and/or emergency response team, if necessary. **If you do NOT want this information shared, please check one of the following:**
___ Share ___ Do Not Share

I hereby give permission for my student to receive the following medical attention as part of the school health program in the Collingswood Public Schools. Please initial "yes" or "no" for all items.

1. Treatment by the school nurse or designee in case of illness or injuries. ___ Yes ___ No
2. Height, weight, blood pressure, vision, hearing, and scoliosis screenings as outlined in the NJ School Health Services Guidelines. ___ Yes ___ No
3. I acknowledge the recommendation of the importance of obtaining a well-child Physical examination during each of my child's developmental stages: ___ Yes ___ No
   - Early childhood (pre-school through 3rd grade)
   - Pre-adolescence (grades 4th through 6th)
   - Adolescence (grades 7th through 12th)

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

FOR SCHOOLS AND PARENTS: K-12 IMMUNIZATION REQUIREMENTS

NJ Department of Health (NJDOH)
Vaccine Preventable Disease Program

Summary of NJ School Immunization Requirements

Listed in the chart below are the minimum required number of doses your child must have to attend a NJ school.* This is strictly a summary document. Exceptions to these requirements (i.e. provisional admission, grace periods, and exemptions) are specified in the Immunization of Pupils in School rules, New Jersey Administrative Code (N.J.A.C. 8:57-4). Please reference the administrative rules for more details https://www.nj.gov/health/cd/imm_requirements/acode/. Additional vaccines are recommended by Advisory Committee on Immunization Practices (ACIP) for optimal protection. For the complete ACIP Recommended Immunization Schedule, please visit http://www.cdc.gov/vaccines/schedules/index.html.

Grade/level child enters school:	Minimum Number of Doses for Each Vaccine						
	DTaP Diphtheria, Tetanus, acellular Pertussis	**Polio Inactivated Polio Vaccine (IPV)**	**MMR (Measles, Mumps, Rubella)**	**Varicella (Chickenpox)**	**Hepatitis B**	**Meningococcal**	**Tdap (Tetanus, diphtheria, acellular pertussis)**
Kindergarten–1st grade	A total of 4 doses with one of these doses on or after the 4th birthday OR any 5 doses†	A total of 3 doses with one of these doses given on or after the 4th birthday OR any 4 doses‡	2 doses§	1 dose‖	3 doses	None	None
2nd – 5th grade	3 doses *NOTE: Children 7 years of age and older, who have not been previously vaccinated with the primary DTaP series, should receive 3 doses of Td. For use of Tdap, see footnote.* †	3 doses	2 doses	1 dose	3 doses	None	See footnote¶
6th grade and higher	3 doses	3 doses	2 doses	1 dose	3 doses	1 dose required for children born on or after 1/1/97 given no earlier than ten years of age¶	1 dose required for children born on or after 1/1/97¶

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

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 _____

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

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 _____

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

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) 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 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?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

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 of exam _____

Address _____ Phone _____

Signature of physician, APN, PA _____

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ 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 _____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____ (Date)

Approved _____ Not Approved _____

Signature: _____

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, 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 _____

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