

Physical Verification Form

This form is to verify that I _____ have already received a physical for _____
(athlete print your name here) (sport)

New Sport

Date

Student's Signature

Athletic Trainer's Signature

Consent and Release

This instrument is to certify that I (if student is 18) or as the parent and/or guardian of _____ in consideration of the benefits to children to be gained through participation in the sports program, do hereby consent to his/her being enrolled as a candidate for a place on the _____ team and that he/she has my permission to undergo a complete sports physical which may include: history, blood pressure, pulse, hernia (boys), scoliosis screening, finger stick blood count, urinalysis for steroid detection and orthopedic exam of shoulders, elbows, knees, and ankles. He/she also has my permission to engage in the interscholastic competition under jurisdiction of the Clifton Board of Education.

Realizing that all sports participation is dangerous, I/we do hereby waive any claim for damages against the Board of Education of Clifton in the County of Passaic, NJ, its employees, officers, members, and participants for death or personal injuries or loss of potential earnings that may result from his/her participation in such sports except for and proceeds of accident or liability insurance policies that may be available for his/her protection.

I/we further release the said Board of Education of Clifton in the County of Passaic, NJ, its employees, members and participants from any and all claims or actions whatsoever based on the transportation of said team or the playing, equipment or operation of said sports programs during the season.

I/we also give permission and consent for the above named athlete to receive medical care from the Clifton High School Sports Medicine staff. This consent allows the Sports Medicine Staff to provide first aid care, injury evaluation and necessary treatment by the Team Physicians or Certified Athletic Trainers under the Team Physician's written, verbal or standing orders. In addition, I/we agree to allow the Clifton High School Sports Medicine department to both receive and release pertinent medical information from/to appropriate authorities (such as physician's offices or hospitals) if said information is requested.

I/we further give permission and consent for the above named athlete to receive treatment by the Clifton High School Sports Medicine staff by order of other licensed physicians who although not on the Clifton High School Sports Medicine staff provide oral or written orders directly to the Sports Medicine staff. The Sports Medicine staff will review these orders with the Clifton High School Team Physician or other staff physician's as deemed necessary prior to providing treatment.

In case of accident or serious illness, I/we request the school to contact me/us. If the school is unable to reach me, I/we hereby authorize the school to make whatever emergency arrangements seem necessary.

(Please Print)

Athlete's Name: _____

Date of Birth: _____ Sport: _____

Year in School: _____ Age: _____

(Please Print)

Parent / Guardian Name: _____

Parent / Guardian Signature: _____

Emergency Phone Number: _____

Date: _____ Gender (male/female) _____ Counselor _____ ID# _____

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

Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the parent and 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:
 - Rash Hives 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 or 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.

**CLIFTON ATHLETIC DEPARTMENT
ELIGIBILITY AND TRAINING RULES**

1. The student must meet state and Board of Education requirements concerning age – academic credits before he/she can participate.

The requirements are as follows:

- A. To participate in Fall and Winter sports, a student must have passed 30 credits to the start of the first semester.
 - B. To participate in a Spring sport, a student must have passed the equivalent of 30 credits at the end of the first semester.
2. Any student, who is found to be possessing, using, transmitting or is under the influence of any alcoholic beverage or substance not prescribed by a physician, shall be suspended from the particular sport he/she is participating in accordance with the Board of Education, Alcohol and Tobacco Policy.
 3. Following a violation, the athlete shall not be allowed to practice or compete in any interscholastic activity until they have complied with the readmission criteria established by the Board of Education.
 4. Athletes who have tested positive for steroids will be ineligible to participate in interscholastic sports for the remainder of the season and shall be assigned to undergo another pre-season physical before being considered eligible for another sport.
if tested positive a second time, the athlete will be ineligible from all interscholastic sports for one year from the date of incident.
 5. Any athlete, who intentionally causes or attempts to cause school damage, steals or attempts to steal school property, is liable for suspension.
 6. Any athlete who intentionally causes physical injury to another person, except in self- defense, is liable for suspension. No student can haze another person in any manner.
 7. Any athlete who does not observe the coach’s particular training rules is liable for suspension.
In the cases of violations of number 5, 6 or 7, the Principal and Athletic Director and head coach will review the case and determine what penalty will be assessed to the student-athlete.

I have read these training rules and agree with them as a parent/guardian and as a student.

I will abide by the rules.

Parent/Guardian’s Signature	Date:	Student’s Signature
Athletic Trainer’s Signature	Sport	Print Student’s Name
Parent’s Name _____ Address _____		
Home Number _____ Work Number _____ Cell Number _____		
Emergency Name & Number _____		
Hospital of Preference _____ Date of Current Physical _____		
Personal Physician (Name & Number) _____		
Medical Conditions (Allergies, Contacts, Asthma, etc) _____		
Medications currently being taken _____		
Grade _____	Gender: Male/Female	Date of Birth _____ Age _____ ID# _____
High School Guidance Counselor _____		