

Katzenbach School for the Deaf
Athletic Department
P0 Box 535, Trenton, NJ 08625-0535

Martha Fowler
Athletic Director

Telephone - 609-530-3183
FAX: 609-530-9035

Dear Parent/Guardians:

Your son/daughter has been chosen to participate on our interscholastic sports teams. Please complete the necessary forms and return them to the Athletic Director, Ms. Martha Fowler, or to the teams' head coach, or you can fax them to 609-530-9035. The following' forms must be completed and returned to school:

1. **Parent Consent Form to participate in a sport** (found at the bottom of this page.)
2. **Pre-Participation Physical Evaluation Form - Health History Questionnaire**
3. **Pre-Participation Physical Examination Form**

a. If you have a family doctor (home physician), your family doctor should do this physical. (For your convenience, a Pre -Participation Physical Examination Form is attached for your family doctor's use when completing the physical examination.)

b. **IMPORTANT:** If you do not have a family physician, check the box, above your signature, on the Pre-Participation Physical Evaluation Form — Health History Questionnaire to have the MKSD doctor do the physical examination.

PARENT CONSENT FORM

I have completed the above information and hereby give my permission for my child to participate in athletics conducted by school authorities. I also consent to his/her participation in the games with other schools as a member of the team. I shall assume au responsibility and expenses not covered by my insurance and the school's athletic insurance for any injury received by my child while in practices or participating in any game or travel to and from a game. I also give my permission for my son/daughter to be examined by the school physician

I so hereby release and hold harmless the said school doctor, State of New Jersey, coaches, and staff, or their representatives, from any and all suits, claims, damages and demands arising out of any injury or death sustained or suffered by my child while engaged in the athletic activity. I have completed in full and understand this form and attest to its accuracy.

Please put an "X" on the sport you are permitting your son/daughter to participate in this season.

Fall Sports	_____ Girls' Volleyball	_____ Soccer
Winter Sports	_____ Cheerleading	_____ Basketball
Spring Sports	_____ Girls' Softball	_____ Track and Field

Print Student's Name: _____ Date: _____

Signature of Parent _____

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

Part A: HEALTH HISTORY QUESTIONNAIRE

(To be completed by the parent and student)

(Pursuant to N.J.A.C. 6A:16 Programs to Support Student Development)

Today's Date: _____

Date of Last Physical: _____

Student's Name: _____

Sex: M F (circle one)

Age: _____

Date of Birth: _____ Sport: _____

Home Phone: _____

Grade: _____ School: _____

District: _____

Physician: _____

Phone: _____

Fax: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to student: _____

Phone (work): _____

Phone (home): _____

Phone (cell): _____

Directions: Please answer the following questions about the student's medical history. Explain all "yes" responses at the bottom of the page. Please respond to all questions.

1. Have you had or do you currently have:

- | | |
|---|--------------------|
| a. A sports physical within the past 365 days? | 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. Use 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. Type of reaction: Rash? Hives? Other skin condition? (Circle all that apply.) | Y / N / Don't Know |
| 2. Take any medication/Epipen taken for allergy symptoms? (List below.) | Y / N / Don't Know |
| h. Any anemias or blood disorders? | Y / N / Don't Know |

2. Have you had or do you currently have any of the following *head-related* conditions since your last physical:

- | | |
|---|--------------------|
| a. Concussion requiring a physician's evaluation? | Y / N / Don't Know |
| 1. How often and when? (Answer below.) | |
| b. Memory loss or been knocked out? | Y / N / Don't Know |
| c. A seizure? | Y / N / Don't Know |
| d. Frequent or severe headaches? | Y / N / Don't Know |

3. Have you had or do you currently have any of the following *heart-related* conditions since your last physical:

- | | |
|---|--------------------|
| a. Chest pain? | Y / N / Don't Know |
| b. Heart murmur? | Y / N / Don't Know |
| c. High blood pressure or elevated cholesterol level? | Y / N / Don't Know |
| d. Restriction from sports for heart problems? | Y / N / Don't Know |
| e. Any family member or relative: | |
| 1. Die of a heart problem before age 35? | Y / N / Don't Know |
| 2. Die of a heart problem before age 50? | Y / N / Don't Know |
| 3. Die with no known reason? | Y / N / Don't Know |
| 4. Die while exercising? During or after? (Circle one.) | Y / N / Don't Know |
| 5. With Marfan's Syndrome? | Y / N / Don't Know |

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

- | | |
|---|--------------------|
| 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 |

5. Have you had or do you currently have any of the following *neuromuscular/orthopedic conditions* since your last physical:

- | | |
|---|--------------------|
| a. 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. A dislocated joint(s)? | Y / N / Don't Know |
| f. Upper or lower back pain? | Y / N / Don't Know |
| g. Fracture(s) or stress fracture(s)? | Y / N / Don't Know |
| h. Do you wear any protective braces or equipment for any prior injury? | Y / N / Don't Know |

6. Have you had or do you currently have any of the following *general or exercise related conditions* since your last physical:

- | | |
|---|--------------------|
| a. Difficulty breathing? During Exercise? (Circle one.) | |
| 1. After running one mile | Y / N / Don't Know |
| 2. Coughing, wheezing or shortness of breathe in weather changes? | Y / N / Don't Know |
| 3. Exercise-induced asthma | Y / N / Don't Know |
| i. Controlled with medication? (List below.) | Y / N / Don't Know |
| ii. Experience dizziness, passing out or fainting? | Y / N / Don't Know |
| b. Viral infections (e.g. mono, hepatitis)? | Y / N / Don't Know |
| c. Become tired more quickly than your friends? | Y / N / Don't Know |
| d. Any of the following skin conditions: | |
| 1. Acne, contact dermatitis, ringworm, warts, herpes? | Y / N / Don't Know |
| 2. Sun sensitivity? | Y / N / Don't Know |
| e. Weight gain/loss (greater than or less than 10 pounds)? | 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 |

7. Females only:

Age of onset of menstruation: _____
Date of last menstruation: _____
Most number of days between menstruation cycle(s): _____

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

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

Parent/Guardian Signature: _____

Date: _____

ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

Part B: Physical Examination (To be completed by the examining physician)

Examination Date: _____

-STUDENT INFORMATION-

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

-PHYSICIAN INFORMATION-

Name: _____ 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

Indicators	Normal? (Circle One)		Abnormal Findings/Comments
Head/Neck	YES	NO	
Eyes/Sclera/Pupils	YES	NO	
Ears	YES	NO	
Nose/Mouth/Throat	YES	NO	
Heart: Murmurs/Rhythms	YES	NO	
Lungs: Auscultation/Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdomen: Assessment (incl. liver, spleen)	YES	NO	
Tanner Stage: Testes/Onset of Menses:	YES	NO	
Neck/Back/Spine: Range of Motion:	YES	NO	
Scoliosis:	YES	NO	
Upper Extremities:	YES	NO	
Lower Extremities:	YES	NO	
Neurological: Balance & Coordination:	YES	NO	
Romberg:	YES	NO	
Heel Walk:	YES	NO	
Tandem Walk:	YES	NO	
Nose Touch:	YES	NO	
Toe Walk:	YES	NO	
Hernia? (if yes/possible, please explain)	YES/ Possible	NO	

Most recent immunizations/Dates:
Medications currently being used:
Additional Observations:

General Diagnosis: _____
 Recommendations: _____

CLEARANCES

A. Student MAY participate in the following sports: (CHECK ALL THAT APPLY)

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

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

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

B. Student MAY participate in following sport(s) ONLY AFTER completing evaluation/rehabilitation: (CHECK ALL THE APPLY)

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

Please specify each condition requiring clearance before participating in a sport in the classification checked above:

Conditions requiring clearance before sports participation include, but are not limited to: 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; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

Physician's/Provider's Stamp:

EXAMINED BY:

Family Physician/Provider _____
 School Physician _____

____ MD ____ DO ____ NP ____ PA

Physician's/Provider's Signature: _____ Date: _____

NOTE TO SCHOOL PHYSICIANS: Pursuant to N.J.A.C. 6A:16-2.2, the school physician shall provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this medical report. Please attach this form to the notification letter and ensure that this report is made part of the student's permanent health record.