MONTGOMERY TOWNSHIP SCHOOL
Skillman, New Jersey

SCHOOL HEALTH SERVICES

Grades 5-12

To: Parent/Guardian
Re: Transfer Student

Pursuant to State Law, N.J.A.C. 6A:16-2.4 (d), all students transferring into a New Jersey Public School, are required to provide an entry physical examination.

If you do not have a report of your child's exam at the time of registration, or your child has not yet had this examination, please check one of the following statements.

____I will have my child examined by a private physician at my expense and within 30 days will submit a report of this examination by the physician.

___ My child has received a physical within the last 365 days. I will submit a report of this examination within 30 days.

_____ _____
Date Student's Name (please print)

_____ _____
Date Parent/Guardian Signature

NOTE:

POSSIBLE SCREENING TEST FOR TUBERCULOSOIS MAY BE REQUIRED FOR YOUR CHILD IF ATTENDING SCHOOL FOR THE FIRT TIME IN THE UNITED STATES OR TRANSFERRING INTO THE NEW JERSEY SCHOOL SYSTEM DIRECTLY FROM A COUNTY THAT IS NOT IDENTIFIED AS A LOW INCIDENCE COUNTY OF TUBERCULOSIS. Please contact the nurse of the school your child will be attending for verification weather or not this tuberculosis screening is required. This mandate is required by the rules of the State Board of Education and the New Jersey Department of Health (N.J. Regulation 6:29-4.2 and state law N.J.S. A. 18A:40-16.)

MONTGOMERY TOWNSHIP SCHOOLS
1014 ROUTE 601 · SKILLMAN, NJ · 08558-2119
PHONE (609) 466-7600

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.

Revised - April 2015

ATTENTION PARENT/GUARDIAN: The pre-participation 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.)

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	**Yes**	**No**
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 _____

9-268100410
HE0503
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		
	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 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 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).

Doctors Office Only

Date of Exam: _____

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[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b] Consider GU exam if in private setting. Having third party present is recommended.
[c] 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) _____ Date _____

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 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 _____

FORM C: School Health Services Form

MONTGOMERY TOWNSHIP SCHOOLS
Skillman, New Jersey

SCHOOL HEALTH SERVICES

Student's Name: _____ Date of Birth: _____
(Please print)

Gender: Male / Female (circle one)

My child previously attended a Montgomery Twp. School Yes / No (circle one)

If yes, circle last school attended OHES VES LMS UMS MHS

HEALTH HISTORY

Has Your Child Had:	NO	YES	YEAR
Chicken Pox			
Heart Problems			
Kidney Problems			
Bladder Problems			
Asthma			
Bronchitis			
Strep Infection			
Mononucleosis			
Diabetes			
Convulsions			
Hepatitis			
Rheumatic Fever			
Pneumonia			

Does Your Child Have:	YES/TYPE	NO
Congenital Defects		
Drug Sensitivities		
Neuromuscular Disease		
Speech Problems		
Vision Problems		
Eyeglasses		
Hearing Problems		

Has your child had:	If yes, description and date.
Any severe injury?	
Any operations?	

Initial the statement that applies to your child:

_____My child does **not** have a life-threatening allergy requiring the use of epinephrine.

_____My child has a life-threatening allergy requiring the use of epinephrine. **Please complete the Life-Threatening Allergy Questionnaire on the following page.***

Parent/Guardian Signature:_____ Date:_____

PLEASE COMPLETE THE NEXT THREE FORMS ONLY IF YOUR CHILD HAS ANY LIFE-THREATENING ALLERGIES.

Montgomery Township Schools

Life-Threatening Allergy/ Asthma Questionnaire*

Grades Preschool - 4

***This form should be completed ONLY if your child has a Life-threatening Allergy**

Student's Name: _____ For School Year: _____

Date of Birth: _____ My Child will be in the following grade during the School Year listed above: _____

1. List all known **life-threatening** allergens (food and non-food):

_____

2. Has your child ever received a shot of epinephrine for an episode of anaphylaxis to any of the allergens listed above?

☐ Yes ☐ No

2a. If yes, briefly describe symptoms: _____

3. Does your child have a prescribed epinephrine auto-injector? ☐ Yes* ☐ No

***A health care provider completed Montgomery Township School District Allergy Action Plan is required if your child has a life-threatening allergy indicating the use of epinephrine in school. The MTSD Allergy Action Plan and other forms can be obtained through your child's school nurse. This form must be renewed every school year.**

4. Will your child carry an epinephrine auto-injector in their backpack during school? ☐ Yes* ☐ No

***Written authorization for your child to carry an epinephrine auto-injector is required from a health care provider- refer to top section on back page of MTSD Allergy Action Plan.**

5. Regarding lunch (complete questions 5 & 6 only if entering grades 1-4, not applicable for students entering Pre-K and K):

☐ My child may purchase school-prepared lunch-

School and cafeteria staff will not make any determination of food safety as related to life-threatening allergens. Parents should review the Chartwell menu in advance of student's purchase. Please refer to the OHES or VES websites under 'Lunch Menu" selection for more information.

☐ My child is not allowed to purchase school-prepared lunch-

Parent will provide daily lunch from home

6. During lunch, my child must sit at: (check only one)

☐ No seating restriction required

☐ Peanut-free table* ☐ Liquid dairy-free table* ☐ Peanut & liquid dairy-free table*

***Only students with a completed Allergy Action Plan for the current school year are allowed to sit at the peanut & liquid dairy-free tables. There will be no exceptions made. The lunchroom aides will have a list of students with life-threatening allergies and will be monitoring the tables for compliance.**

7. Does your child have asthma? ☐ Yes ☐ No 7a. Will you provide an inhaler to keep at school? ☐ Yes* ☐ No

*** As per: N.J.S.A. 18A:40-12.8, a health care provider completed NJ Asthma Treatment Plan is required if your child uses an inhaler during school, even if they are not diagnosed with asthma. See school nurse for this form.**

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

The following to be completed by School Nurse:

1. Epinephrine provided: ☐ Yes ☐ No **2. AAP provided:** ☐ Yes ☐ No **3. IHP completed:** ☐ Yes ☐ No

4. IHP signed by parent: ☐ Yes ☐ No **5. Transportation notified:** ☐ Yes ☐ No **6. Genesis updated:** ☐ Yes ☐ No

Notes:

_____

_____

Montgomery Township School District

Emergency Allergy Action Plan

School Year: _____

Affix Student's Picture Here

Student's Name: _____ DOB: ____/____/____

Teacher: _____ Home Room: _____ Grade: _____

Physician/Health Care Provider to complete & sign:

List all known life-threatening allergens: _____

Asthma: ☐- **Yes (increased risk of severe reaction)** ☐- **No**

The following statements apply ONLY to food allergens:
Extremely Reactive to the following food(s): _____
Therefore:
☐If checked, give epinephrine immediately for any symptoms if the allergen was likely eaten.

☐If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

SEVERE SYMPTOMS after suspected or known ingestion or exposure to allergen:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, Blue, Faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble swallowing or breathing
MOUTH:	Obstructive swelling (tongue and /or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itch rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911 – Request Ambulance with epinephrine
3. Continually monitor student's condition
4. Administer antihistamines & inhaler/ bronchodilator† if asthma (only RNs may administer)*

*Delegates are not authorized to administer antihistamines or bronchodilators per statute- N.J.S.A. 18A:40-12.6.

†Antihistamines & Inhaler-bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE!**

Medications/Dosage:

Epinephrine (auto-injector dose): _____

Administer a second dose of epinephrine if student's condition does not improve within 10-15 minutes after the first dose is given: YES/NO

Antihistamine (dose): _____
(*Delegate cannot administer)

Other (e.g., inhaler-bronchodilator if asthmatic): _____
(*Delegate cannot administer)

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth/throat
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/stomach ache

1. **GIVE ANTIHISTAMINE***
2. Monitor student's condition
3. If symptoms progress (see above).

USE EPINEPHRINE!

Antihistamine (dose): _____
(*Delegate cannot administer)

TURN FORM OVER

Capacity for self-administration of epinephrine
Physician/Healthcare Provider should initial applicable statement:

_____ Student **must carry** his/her epinephrine during the school day and is **capable of self-administration**. He/she has received instruction, and demonstrates the proper use of epinephrine using a training device. **If for any reason the student cannot self-administer, the nurse, or delegate will administer the epinephrine.** I understand that a delegate cannot administer antihistamines.

_____ Student **does not have the capacity for self-administration** of epinephrine, but will **carry** this medication to be administered by a nurse or delegate in the event of an emergency. Transportation services will be notified. I understand that a delegate cannot administer antihistamines.

_____ Student **does not have the capacity** for self-administration of epinephrine. An auto-injector of epinephrine will be provided to the nurse's office at the beginning of each school year and a nurse or delegate will administer this medication as needed.

X_____/_____
Physician/Healthcare Provider Signature *Date*

MD Stamp Here

Emergency Contact Information:

Please PRINT LEGIBLY contact names and phone numbers in order of priority

_____/_____/_____
1. Parent/Guardian Name (PRINT) *Preferred Phone* *Alternate phone number*

_____/_____/_____
2. Parent/Guardian Name (PRINT) *Preferred Phone* *Alternate phone number*

_____/_____/_____
3. Parent/Guardian Name (PRINT) *Preferred Phone* *Alternate phone number*

PLEASE NOTE: For students with diagnosed life-threatening allergies, the following bulleted items must be provided & updated each school year for emergencies during school and off-campus events (e.g. field trip, overnight trip, sports.)

- All emergency medications as noted by the student's physician with current expiration date
- If a 2nd dose of epinephrine is authorized by Health Care Provider (see front of form), please provide two auto-injectors.

Please be advised that your child will not be allowed to participate in athletics, field trips, overnight trips or school sponsored events without a completed and current MTSD Allergy Action Plan on file in the health office.

I understand that in the event of an anaphylactic emergency, epinephrine will be administered to my child by a school nurse and/or delegate as indicated in this allergy action plan. My signature below indicates my acknowledgement that the school district and its employees or agents shall have no liability as a result of any injury arising from the administration of epinephrine to my child. I shall indemnify and hold harmless the district and its employees or agents against any claims arising out of the administration of epinephrine via a pre-filled auto injector mechanism.

Parent/Guardian Signature: X_____ *Date:*_____

School Nurse Signature: X_____/ *Date:*_____

Revised 06/08/15