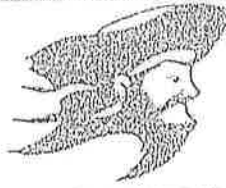


Belleville Buccaneers  
Athletics Department  
Office: 973-450-3500  
x1005  
Cell: 862-926-8486



Mr. Marcellino Marra  
Athletic Director  
Belleville High School  
Marcellino.Marra@Belleville.k12.nj.us

**THIS PACKET IS FOR STUDENTS THAT HAVE NOT HAD A PHYSICAL WITHIN 365 DAYS (1 YEAR)**

**Welcome to Belleville Athletics!!!!**

In this packet you will find only the athletic physical which must be read and completed by both the parent(s)/guardian(s) and the student-athlete wishing to participate in our athletic programs. To complete the following items, please go to [BellevilleAthletics.org](http://BellevilleAthletics.org) and click on "online registration."

**NOTE:** The first time you sign in; you will have to create an account:

1. A memo addressing Physical Requirements & Procedures – Review/electronically sign at [BellevilleAthletics.org](http://BellevilleAthletics.org).
2. A memo addressing Academic Eligibility- review/electronically sign at [BellevilleAthletics.org](http://BellevilleAthletics.org).
3. An Athletic Department Communications Pamphlet – Review/electronically sign at [BellevilleAthletics.org](http://BellevilleAthletics.org).
4. NJSIAA Steroid Testing Policy – review/electronically sign at [BellevilleAthletics.org](http://BellevilleAthletics.org).
5. Sudden Cardiac Communication Pamphlet/Sign-Off Sheet-Review/electronically sign at [BellevilleAthletics.org](http://BellevilleAthletics.org)
6. NJSIAA Concussion Acknowledgement Form-Review/electronically sign at [BellevilleAthletics.org](http://BellevilleAthletics.org).
7. Athletic Handbook Agreement-Review/Electronically sign at [BellevilleAthletics.org](http://BellevilleAthletics.org).
8. Media Release Form-Review/electronically sign at [BellevilleAthletics.org](http://BellevilleAthletics.org)
9. Parent/Guardian Emergency Information-Review/fill out/electronically sign at [BellevilleAthletics.org](http://BellevilleAthletics.org).
10. Opioid Drugs Fact Sheet- Review/Electronically sign at [BellevilleAthletics.org](http://BellevilleAthletics.org).

**The following items remain a part of the hard-copy packet and must be filled out, signed and returned to the Athletics Office:**

1. Pre-participation Physical Evaluation/History Form-Fill out, sign & return with Physical.
2. Pre-participation Physical Evaluation/Physical Special Needs Form
3. Pre-participation Physical Evaluation/Physical Examination Form-Filled out by Physician, Returned by Parent/Guardian.
4. Pre-participation Physical Evaluation/Clearance Form-Filled out by Physician, returned by parent/guardian.
5. BHS Parent Notification letter-MUST be returned.

Items 1 through 3 should be retained for your personal reference. Items 4 through 14 MUST be returned by the below dates for your child to be able to participate in any form of Interscholastic Athletics.

**FALL DUE DATE**  
**July 15, 2019**

**WINTER DUE DATE**  
**November 11, 2019**

**SPRING DUE DATE**  
**February 10, 2020**

Thank you for your anticipated cooperation in helping us provide, enjoyable athletic experience for your child.

**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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections<br>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:<br><input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur<br><input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection<br><input type="checkbox"/> 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 \_\_\_\_\_

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HE0503

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

9-2681/0410

# 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   |            |           |
|  | <b>Yes</b> | <b>No</b> |
| 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

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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

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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 \_\_\_\_\_

**NOTE:** The preparticipation 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

- 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

| EXAMINATION  |        |  |
|--|--------|--|
| Height   | Weight | <input type="checkbox"/> Male <input type="checkbox"/> Female                      |
| BP / ( / )   | Pulse  | Vision R 20/ L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N |
| MEDICAL  | NORMAL | ABNORMAL FINDINGS  |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnoidactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) |        |  |
| Eyes/ears/nose/throat<br>• Pupils equal<br>• Hearing   |        |  |
| Lymph nodes  |        |  |
| Heart*<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI)  |        |  |
| Pulses<br>• Simultaneous femoral and radial pulses   |        |  |
| Lungs  |        |  |
| Abdomen  |        |  |
| Genitourinary (males only) <sup>b</sup>  |        |  |
| Skin<br>• HSV, lesions suggestive of MRSA, tinea corporis  |        |  |
| Neurologic <sup>c</sup>  |        |  |
| MUSCULOSKELETAL  |        |  |
| Neck   |        |  |
| Back   |        |  |
| Shoulder/arm   |        |  |
| Elbow/forearm  |        |  |
| Wrist/hand/fingers   |        |  |
| Hip/thigh  |        |  |
| Knee   |        |  |
| Leg/ankle  |        |  |
| Foot/toes  |        |  |
| Functional<br>• Duck-walk, single leg hop  |        |  |

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.  
<sup>c</sup>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 \_\_\_\_\_