Burlington City High School
Physical Examination & Athletic Trainer System
Information Form

**Required Forms**

1. Preparticipation Physical Evaluation
   a. History Form (*Form A2*) *(Requires Parent/Guardian & Athlete Signatures)*
   b. The Athlete with Special Needs: Supplemental History Form (*Form A3*) *(Requires Parent/Guardian & Athlete Signatures)*
   c. Forms B1 and B2 are to be completed by examining physician.

**Only Required IF APPLICABLE**

1. Self-Administration of Medication (*Form C1*)
   *(Requires Personal Physician, Parent/Guardian, & School Nurse Signatures)*

2. Authorization for the Administration of Medications by the School Nurse (*Form C2*)
   *(Requires Personal Physician & Parent/Guardian Signatures)*

3. Indemnification/Hold Harmless Agreement for Self-Administration of Medication (*Form C3*)
   *(Requires Parent/Guardian & School Nurse Signatures)*
Additional Requirements

**Athletic Trainer System (ATS) online requirements.**

Parent signatures are required.

**Athletic Trainer System (ATS) Required Forms:**

- Permission Form for Athletic/Activity Competition
- NJSIAA Steroid Testing Policy Consent to Random Testing - allows for the possible testing of any athlete that qualifies for the NJSIAA tournament in their respective sport.
- Sudden Cardiac Death in Young Athletes
- Prevention and Treatment of Concussions and Head Injuries Policy and NJSIAA Parent/Guardian Concussion Policy Acknowledgement Form
- Eye Injuries in Sports
- Health History Update Form Required when an athlete’s physical was completed more than 90 days prior to the start of practice for the season in which the student wishes to participate.
- Opioid Use and Misuse Educational Fact Sheet
- BCHS Interscholastic Athletics Handbook Acknowledgement Form
- NJSIAA Opioid Acknowledgement Form

**New to the Athletic Trainer System?**

If using the system for the first time, your initial username and password are “new”.

**ATS Login Website:**

**Need Assistance?**

Athletic Trainer, Mr. Jesse Totoro:
jtotoro@burlington-nj.net or 609-387-5814

Athletic Director, Mr. Nick Rancani:
nrancani@burlington-nj.net or 609-387-5986
Supplemental Accident Insurance

The City of Burlington Public Schools has purchased supplemental accident insurance to protect students participating in interscholastic athletics or activities. This policy is secondary to the student's primary health insurance. Any injuries must be reported to the coach/advisor or athletic trainer immediately. Claim forms are available at the school.

Parents should understand that medical expenses are their own responsibility, NOT the Board of Education.
Burlington City High School
School Doctor Preparticipation
Physical Examination Consent Form

ONLY COMPETE IF USING SCHOOL DOCTOR

I/We give permission for the school doctor, Bruneau Family Care, P.C., to perform a sports physical on my child:

Child’s Name: ____________________________________________

Grade: ____________

I/We give permission for ________________________________________ to participate in organized school athletics, realizing that such activity involves the potential for injury, which is inherent in all sports. I/we acknowledge that even with the best coaching, use of the most advanced protective equipment, and strict observance of rules, injuries are still a possibility. On rare occasions, these injuries can be so severe as to result in total disability, paralysis, or even death.

Parent/Guardian Signature: ______________________________________

Date: ______________

ALL NECESSARY PAPERWORK MUST BE COMPLETED PRIOR TO SCHEDULING A PREPARTICIPATION PHYSICAL.
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

Grade_______

Best contact phone #_______

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep copy of this form in the chart.)

Date of Exam

Name

Sex

Age

Grade

School

Sport(s)

Date of birth

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

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 □ Arthritis □ Diabetes □ Infections □ Other

3. Have you ever spent the night in the hospital?

4. Have you ever had surgery?

HEART HEALTH QUESTIONS ABOUT YOU

5. Have you ever passed out or nearly passed out DURING or AFTER exercise?

6. Have you ever had dizziness, faintness, white vision, or pressure in your chest during exercise?

7. Does your heart 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

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, hemochromatosis, or long QT syndrome, or sickle cell trait or disease?

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

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 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

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 (male), your spleen, or any other organ?

30. Do you have a groin pain or a painful budge or lump in the groin area?

31. Have you had infectious mononucleosis (mononucleosis) 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 many periods have you had in the past 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


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

FORM A2
# Preparticipation Physical Evaluation

## The Athlete with Special Needs: Supplemental History Form

<table>
<thead>
<tr>
<th>Date of Exam</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Name

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

### 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.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enlarged spleen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteopenia or osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in arms or hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spina bifida</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latex allergy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Signature of athlete</th>
<th>Signature of parent/guardian</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

FORM A3
**Preparticipation Physical Evaluation**

**Physical Examination Form**

**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?
   - Have you ever had a history of substance abuse?
   - Have you ever had alcohol or 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**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>/</td>
</tr>
<tr>
<td>Vision</td>
<td>R 20/</td>
</tr>
<tr>
<td>Corrected</td>
<td>Y</td>
</tr>
</tbody>
</table>

**Medical**

- Appearance
  - Marfan symptoms (e.g., high-arched palate, pectus excavatum, arachnodactyly, arm span / height, hyperplasia, myopia, MVP, aortic insufficiency)

- Eyes
  - 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
  - NPS lesions suggestive of MRSA, Ilex corporis

- Neurological

**Musculoskeletal**

- Neck
- Back
- Shoulder/Arm
- Elbow/Forearm
- Wrist/Hand/Fingers
- Hip/Thigh
- Knee
- Leg/Ankle
- Foot/Toes
- Functional
  - Duck-walk, single leg hop

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*Consider EKG, echocardiogram, and referral to cardiologist for abnormal cardiac history or exam.
*Consider CT exam if private setting. Having third party present is recommended.

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☐ 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

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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

Address

Signature of physician, APN, PA

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

FORM B1
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: SCHOOL NURSE:

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 ___________________________ DATE OF EXAM: _____________

Completed Cardiac Assessment Professional Development Module

Date _______ Signature ____________________________


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

FORM B2
City of Burlington Public Schools
Burlington, New Jersey

SELF-ADMINISTRATION OF MEDICATION

New Jersey Department of Education Guidelines and Regulations prohibit any student from having medication in his/her possession during the school day. Students with asthma or other life-threatening conditions are permitted to carry and self-administer medications which have been specifically prescribed by a physician and authorized by the school. Medications orders are to be renewed each year.

(The following is to be completed by the physician)

Student: ___________________________ Grade: ___________________________

Diagnosis: __________________________________________________________________________

Medication: __________________________________________________________________________

Dosage and Frequency: __________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

* I certify that this student has been instructed on the use and administration of the Inhaler or/and Epi-Pen (please circle the appropriate medication) and may self-administer the medication during school hours.

PHYSICIAN SIGNATURE: ___________________________ DATE: ___________________________

PHYSICIAN’S NAME: ___________________________ PHONE: ___________________________

_____________________________________________________________________________________

(The following is to be signed by the parent/guardian and school nurse)

I give the School Nurse permission to share this information with teachers, coaches, and other individuals in charge of school activities where self-administration of medication may occur.

PARENT/GUARDIAN SIGNATURE: ___________________________ PHONE: ___________________________

NURSE’S SIGNATURE: ___________________________ DATE: ___________________________

Revised 8/2016

FORM C1
City of Burlington Public Schools
Burlington, New Jersey

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS BY THE SCHOOL NURSE

(The following is to be completed by the physician)

Child’s name: __________________________ Grade: ______ Child’s Diagnosis: ________________________________

Medication: __________________________ Dosage: ________________________________

Frequency or time of day to be given at school: ________________________________

If medicine is to be given when needed, please describe conditions: ________________________________

Please list any significant side effects: _______________________________________________________

Known allergies/ other information: _______________________________________________________

In addition, please note below whether the above named student may or may not have his/ her daily medication suspended for a field trip. Please understand that efforts will be made to employ a substitute nurse to accompany the class when students with health/medication needs are in attendance. The district cannot always guarantee the availability of a substitute nurse. A parent/guardian may accompany the student on a field trip for the purpose of administering medication.

YES ______ NO ______ This drug may be omitted on half days.

YES ______ NO ______ This drug may be omitted on field trips.

PHYSICIAN SIGNATURE (Stamped signature not acceptable): __________________________ DATE: ______

PHYSICIAN NAME (Please print): __________________________________ PHONE: ________________

*Please note, if a child has a potentially life threatening condition, the Self-Administration of Medication form (Form C1) must be completed and signed by both the ordering physician and the parent prior to the student being allowed to carry his/her medication.

(The following must be completed by the parent/guardian)

I request that my child be assisted by the school nurse in taking medication(s) as prescribed by my child’s physician. I realize that I must renew this certificate annually. I also give the school nurse permission to contact the physician in regards to matters concerning my child’s medication or condition. I understand that the school district and its employees and agents shall incur no liability as a result of any injury arising from the administration of medications, including epinephrine, of my child. I further understand that I hereby indemnify and hold harmless the school district and its employees and agents against any injury or claims arising out of the nurse’s administration of my child’s medications, including the administration of epinephrine to my child when the nurse is not physically present at the scene.

PARENT/GUARDIAN SIGNATURE: __________________________ DATE: ______________________

PHONE: __________________________

Revised 8/2016
FORM C2
INDEMNIFICATION/HOLD HARMLESS AGREEMENT FOR SELF-ADMINISTRATION OF MEDICATION

The parent(s)/guardian(s) agree(s) to indemnify, defend, and hold the school district harmless from any and all claims, actions, costs, expenses, damages, and liabilities, including attorney’s fees arising out of/or connected with or resulting from self-administration of medication by the pupil. The parent(s)/guardian(s) agree(s) to extend this indemnification/hold harmless agreement to the Board of Education, Board of Education employees and its agents. The parent(s)/guardian(s) agree(s) the school district, Board of Education, Board of Education employees and its agents shall incur no liability as a result of any injury out of or connected with self-administration of medication by the pupil.

This agreement shall take effect on the date listed below and shall stay in effect for as long as the pupil is provided permission to self-administer medication. This agreement must be signed and in full effect prior to the granting of permission to self-administer medication.

(The following must be completed by the parent/guardian and school nurse)

STUDENT’S NAME: ____________________________________________

PARENT/GUARDIAN’S NAME: ______________________________________

PARENT/GUARDIAN’S SIGNATURE: ___________________________ DATE: __________

SCHOOL NURSE’S SIGNATURE: ______________________________ DATE: __________