# 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.)

<table>
<thead>
<tr>
<th>Date of Exam</th>
<th>Name</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
<th>Date of birth</th>
</tr>
</thead>
</table>

### Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

- [ ] Medicines
- [ ] Pollens
- [ ] Food
- [ ] Stinging insects

### Do you have any allergies? □ Yes □ No

If yes, please identify specific allergens below:

- [ ] Medicines
- [ ] Pollens
- [ ] Food
- [ ] Stinging insects

### Explain "Yes" answers below. Circle the answer that best describes your condition:

#### General Questions

1. Has a doctor ever denied or restricted your participation in sports for any reason? □ Yes □ No

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? □ Yes □ No

4. Have you ever had surgery? □ Yes □ No

#### Heart Health Questions

5. Have you ever passed out or nearly passed out during or after exercise? □ Yes □ No

6. Have you ever had chest pain, tightness, or pressure in your chest during exercise? □ Yes □ No

7. Does your heart ever race or skip beats (irregular beats) during exercise? □ Yes □ No

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) □ Yes □ No

10. Do you get lightheaded or feel more short of breath than expected during exercise? □ Yes □ No

11. Have you ever had an unexplained seizure? □ Yes □ No

12. Do you get more tired or short of breath more quickly than your friends during exercise? □ Yes □ No

#### Heart Health Questions about your Family

13. Has any family member or relative died of heart disease or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? □ Yes □ No

14. Does anyone in your family have hypertrrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? □ Yes □ No

15. Does anyone in your family have a heart problem, pacemaker, or implantable defibrillator? □ Yes □ No

16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? □ Yes □ No

#### 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? □ Yes □ No

18. Have you ever had any broken or fractured bones or dislocated joints? □ Yes □ No

19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? □ Yes □ No

20. Have you ever had a stress fracture? □ Yes □ No

21. Have you ever been told that you or have you had an x-ray for neck instability or atlantoaxial instability (Down syndrome or dwarfism)? □ Yes □ No

22. Do you regularly use a brace, orthosis, or other assistive device? □ Yes □ No

23. Do you have a bone, muscle, or joint injury that bothers you? □ Yes □ No

24. Do any of your joints become painful, swollen, feel warm, or look red? □ Yes □ No

25. Do you have any history of juvenile arthritis or connective tissue disease? □ Yes □ No

### Medical Questions

26. Do you cough, wheeze, or have difficulty breathing during or after exercise? □ Yes □ No

27. Have you ever used an inhaler or taken an asthma medicine? □ Yes □ No

28. Is there anyone in your family who has asthma? □ Yes □ No

29. Were you born without or are you missing a kidney, an eye, a testicle (male), your spleen, or any other organ? □ Yes □ No

30. Do you have joint pain or a painful bump or tissue in the groin area? □ Yes □ No

31. Have you had infectious mononucleosis (mono) within the last month? □ Yes □ No

32. Do you have any rashes, pressure sores, or other skin problems? □ Yes □ No

33. Have you ever had a herpes or MRSA skin infection? □ Yes □ No

34. Have you ever had a head injury or concussion? □ Yes □ No

35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? □ Yes □ No

36. Do you have a history of seizure disorder? □ Yes □ No

37. Do you have headaches with exercise? □ Yes □ No

38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? □ Yes □ No

39. Have you ever been unable to move your arms or legs after being hit or falling? □ Yes □ No

40. Have you ever become II while exercising in the heat? □ Yes □ No

41. Do you get frequent muscle cramps when exercising? □ Yes □ No

42. Do you or someone in your family have sickle cell trait or disease? □ Yes □ No

43. Have you had any problems with your eyes or vision? □ Yes □ No

44. Have you had any eye injuries? □ Yes □ No

45. Do you wear glasses or contact lenses? □ Yes □ No

46. Do you wear protective eyewear, such as goggles or a face shield? □ Yes □ No

47. Do you worry about your weight? □ Yes □ No

48. Are you trying to or have you been recommended that you gain or lose weight? □ Yes □ No

49. Are you on a special diet or do you avoid certain types of foods? □ Yes □ No

50. Have you ever had an eating disorder? □ Yes □ No

51. Do you have any concerns that you would like to discuss with a doctor? □ Yes □ No

### Females Only

52. Have you ever had a menstrual period? □ Yes □ No

53. How old were you when you had your first menstrual period? □ Yes □ No

54. How many periods have you had in the last 12 months? □ Yes □ No

### 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: ______________ Date: ______________

Signature of parent/guardian: ______________ Date: ______________


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

S-2261/0410
NEW JERSEY HEALTH REQUIREMENTS FOR SCHOOL ATTENDANCE

It is a New Jersey law that a student must have a health physical evaluation by a New Jersey licensed medical provider. A school representative and/or your homestay family will help you arrange for your physical evaluation once you arrive to New Jersey.

What do I need to bring with me when I have my health physical examination performed by a medical provider in the United States?

- **Medical History Form** completed by your parent prior to your physical evaluation in NJ (see attachment)
- **Immunization Record**
- **Health History Booklet for Travel** (if you have one)
- **TB Screening Test Results**

<table>
<thead>
<tr>
<th>Required Medical Screenings</th>
<th>Meets Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tuberculosis (TB/Mantoux Screening Test</strong></td>
<td>Documentation of a Tuberculosis (TB/Mantoux) screening test performed in the last six months. If the results were positive the follow up chest x-ray report is also required.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Required Immunizations</th>
<th>Meets Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DTP</strong></td>
<td>3 doses</td>
</tr>
</tbody>
</table>
| **Tetanus, Diphtheria, Acellular Pertussis (Tdap)** | 1 dose of Tdap if born on or after 1/1/97 and entering or attending Grade 6 or higher  
*Given no earlier than the 10th birthday  
*Children who received a Td booster dose within the past 5 years shall not be required to receive Tdap until five years from the last DTP, DTaP or Td  
* Children born on or after January 1, 1997, and transferring into a New Jersey school from another state or country, shall have received one dose of Tdap, provided at least five years have elapsed from the last documented Td dose |
| **Polio** | 3 doses  
*Note: 18 years of age or older not required |
| **Measles** | 2 doses  
*Note: both must be on or after the first birthday and at least one month apart OR laboratory evidence of immunity |
| **Mumps** | 1 dose on or after first birthday OR laboratory evidence of immunity |
| **Rubella/German Measles** | 1 dose on or after first birthday OR laboratory evidence of immunity |
| **Hepatitis B** | 3 doses  
OR laboratory evidence of immunity |
| **Varicella/Chicken Pox** | 1 dose after the first birthday if born after 1/1/98  
OR laboratory evidence of immunity  
OR healthcare provider or parental written statement of previous varicella/chicken pox disease |
| **Meningococcal Conjugate Vaccine (MCV4)** | 1 dose if born on or after 1/1/97 and entering or attending Grade 6 or comparable unassigned grade  
* Every child born on or after January 1, 1997, and transferring into a New Jersey school from another state or country on or after September 1, 2008, shall have received one dose of meningococcal vaccine.  
* Applies to students when they turn 11 years old |