FRANKLIN PUBLIC SCHOOLS
HIGH SCHOOL  ATHLETICS  MIDDLE SCHOOLS
PRINT ALL INFORMATION

NAME ___________________________  GRADE ___________  STUDENT # ___________
  LAST NAME,  FIRST NAME

_____________________________

SPORT

_____________________________

SCHOOL

FTPS
SPORTS PHYSICAL PACKET
ALL SPORTS MEDICAL EXAMINATIONS BY A MEDICAL DOCTOR ARE VALID FOR 365 DAYS

PARENT / STUDENT GUIDE FOR ATHLETIC PARTICIPATION,
MEDICAL CLEARANCE AND INSURANCE COVERAGE

RETURN FTPS SPORTS PHYSICAL PACKET DIRECTLY TO:
FOLLOWING LOCATIONS:
FHS ATHLETIC OFFICE (D-121)
FMS: PE TEACHERS
SGS: PE TEACHERS
Explain “Y
Sex ______ Age __________ Grade ___________ School ___________________________ Sport(s) __________________________________
Name __________________________________________________________________________________ Date of birth __________________________
Date of Exam ___________________________________________________________________________________________________________________

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  □ 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
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?
6. Do you have any heartbeat that is not regular?
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 feel 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, unexpected 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
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?

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 __________________________

# Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

**Date of Exam**

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

**Sex**

<table>
<thead>
<tr>
<th>Age</th>
<th>Grade</th>
<th>School</th>
<th>Sport(s)</th>
</tr>
</thead>
<tbody>
<tr>
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</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>
<tbody>
<tr>
<td></td>
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</tbody>
</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>Atlantoaxial instability</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<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>
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</tbody>
</table>


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

**Physical Examination Form**

<table>
<thead>
<tr>
<th>Name __________________________</th>
<th>Date of birth ____________________</th>
</tr>
</thead>
</table>

#### 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?

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

#### Examination

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

**Medical**

<table>
<thead>
<tr>
<th>Findings</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/ears/nose/throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary (males only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Musculoskeletal**

<table>
<thead>
<tr>
<th>Findings</th>
<th>Neck</th>
<th>Back</th>
<th>Shoulder/arm</th>
<th>Elbow/forearm</th>
<th>Wrist/hand/fingers</th>
<th>Hip/thigh</th>
<th>Knee</th>
<th>Leg/ankle</th>
<th>Foot/toes</th>
<th>Functional</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Duck-walk, single leg hop</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tbody>
</table>

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
*Consider GU exam if in private setting. Having third party present is recommended.
*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________________________


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