AUDUBON JR.-SR. HIGH SCHOOL
Department of Athletics – Green Wave Sports
350 EDGEWOOD AVENUE
AUDUBON, NEW JERSEY 08106-2299
PHONE: 856-547-7695 / Ext.4127
FAX: 856-522-1120

JOHN H. ROSS
Principal

Donna L. Covely
Assistant Principal for Athletics

2010 – 2011 School Year **REVISED ATHLETIC PARTICIPATION PACKET**

Dear Parent/Guardian:

This packet has been prepared so that your child has a successful and rewarding athletic experience. In order to do so he or she must become acquainted with all rules, regulations and procedures pertaining to the Audubon High School Athletic Program.

Please review the following information related to each section of this packet:

SECTION I ▪General Information

SECTION II ▪Code of Ethics and Regulations for Student Extra Curricular Activities

■**Code of Ethics and Regulations and Athletic Participation and Release Form** – completed by parent or guardian and signed by student and **MUST BE TURNED IN EACH SEASON.**

■ **NJSIAA Steroid Testing Policy Consent to Random Testing Form. MUST BE TURNED IN EACH SEASON.**

SECTION III Medical Information

- ■ Athletic Training Procedures
- ■ Insurance Information
- ■ Asthma Treatment Plan – Completed by Physician only for athletes with Asthma
- ■ **N.J. D. O. E. Athletic Pre-participation Examination Form (yellow form)**

Part A Health History Questionnaire –Completed by parent or guardian within 60 days of the first official practice– **MUST BE TURNED IN EACH SEASON.**

Part B Physical Examination (green form) Completed by Physician **REVISED MAY 1, 2010.**. This form does **NOT** have to be turned in each season if current physical is on file. A Physical Examination is good for **364 Days** from date of exam.

■ Emergency Card – completed by parent or guardian –**MUST BE TURNED IN EACH SEASON**.

All paperwork should be returned to Mrs. Mierkowski in the Breezeway or C-102, the Attendance Office by Monday November 1, 2010 during summer break please bring packets to room C-102, if the office is locked please slide forms under the door.

Any confusion whatsoever please do not hesitate to call me at 856-547-7695 ext. 4123.

Sincerely,

Donna L. Covely

Donna L. Covely
Assistant Principal for Athletics

Doctors must review Health History Questionnaire at time of physical

SECTION l
GENERAL INFORMATION

2010 – 2011 School Year

ELIGIBILITY

Every athlete is responsible for certain eligibility standards:

(A) Academic

All students will be required to pass 27.5 credits during the prior school year including summer school. In addition to the minimum state eligibility rules set forth in the Board of Education File 6145.2, a student must maintain a G.P.A. of 1.50 or greater and/or receive no more than one F per marking period. Said G.P.A. will be reviewed each of the first three marking periods for current eligibility. Should G.P.A. fall below 1.50 in any marking period, the student is ineligible for the next full marking period of the school year. Students are required to pass 13.75 credits from the 1st semester of the current school year to be eligible to participate during the 2nd semester of same school year.

(B) Age

Any student who turns 19 prior to September 1, loses his/her school eligibility.

(C) Attendance

Attendance in school is required for an athlete to participate. If you are too sick to be in school, you will not be able to be part of an activity that day or night. The only exceptions are college visitations, driving tests, dentist appointments, eye doctor appointments, and doctor's appointments for any reason other than illness. A student with a first period class who signs in after home room or a student with a second period class who signs in after 9:13 AM will be considered ineligible for activities that day.

EQUIPMENT

Every athlete is responsible for all equipment assigned. Do not leave any equipment in an open locker. Do not leave game uniforms in your locker overnight. Do not give anyone the combination to your locker. If your equipment is stolen you will be responsible. Equipment is very expensive and increasing in cost every year. Our costs range from a $35 jersey to $125 helmet.

INSURANCE AND INJURIES

The insured athlete should obtain a claim form from the school nurse and medical information form from the school's athletic trainer. It is important that this procedure be followed both for prompt and efficient payment of medical bills and to facilitate communication between the attending physician and our school's medical personnel.

TRANSPORTATION

All of our athletes are expected to exhibit proper behavior when traveling to and from their school events. Erratic behavior such as throwing objects from the bus, profanity, obscene gestures or any other behavior considered to be in bad taste on the bus will result in serous action taken.

QUITTING PROCEDURE

We strongly encourage you to complete the season you start, but if you decide to quit be sure to turn in your equipment immediately. If you leave equipment in your locker someone is going to get at anything that is appealing. **Do not give your equipment to a team manager. It must be turned in to a coach within 48 hours of your departure from the squad.**

ACADEMICS

It shall be the policy of the Athletic Department to promote and foster academic achievement. All athletes in need of additional classroom reinforcement from their teachers are encouraged to do so with the full support of this department. These latenesses to practice will be considered **valid** with both proper notification and documentation.

NOTE: If you have a problem, discuss it with your coach. It may prevent a greater problem in the future.

SECTION II
CODE OF ETHICS AND REGULATIONS
FOR STUDENT EXTRA CURRICULAR ACTIVITIES

The Audubon School District affirms that a Code of Ethics and Regulations is imperative to a successful program. It is essential that each advisor or coach adhere to the following code to reach the desired uniformity of purpose. School related activities have, as a main objective, the development of responsibility to oneself and others. In addition, experience has shown that where there is a breakdown in our rules and regulations, the program suffers. To achieve this goal, all students who participate in an extra curricular program must first meet the Audubon Board of Education Policy.

Any participant guilty of the following infractions will be expelled or suspended:

(A) **PERMANENT EXPULSION:** The following refers to occurrence which occur during school hours or at school sponsored functions. The occurrence also refers to the time period which corresponds to the course of an activity or athletic season. Note: Students are legally able to be disciplined by the school for violations committed off school grounds or violations committed after school hours. Enforcement of this code would be the responsibility of the disciplining administrator. Also, an expulsion for a year long activity will be equivalent to a three month period. Two expulsions from the same year long activity will necessitate removal for the remainder of the year:

1. Any attitude or behavior which is considered by the disciplining administrator to be detrimental to the ethical principles of the group or reflects poorly on the Audubon School system.

2. Any use of, possession, distribution of alcoholic beverages and drugs.

3. Smoking or other use of tobacco such as chewing tobacco.

4. Involvement in theft.

5. More than a total of five days suspension over the course of the year for any disciplinary reason other than lateness, or two incidents of suspension during any one season. Any suspension accrued after spring sport season ends will result in probation and possible expulsion for the following activity/sport in which student participates
.

B **SUSPENSIONS:**

1. Flagrant violation of coach/advisor established curfew.

2. Cheating on a test.

3. Instances of insubordination or disrespect toward a teacher as recommended by the disciplining administrator.

4. Day(s) in which a student is on home suspension. This means any student on home suspension will not be permitted to participate in an activity or event that day or night.

5. Any other minor situation which the supervisor feels necessary.

This form must be completed each season

CODE OF ETHICS AND REGULATIONS FOR STUDENT EXTRA CURRICULAR ACTIVITIES

I have read the Code of Ethics and Regulations for Student Extra Curricular Activities.

____
Signature of Parent or Guardian

____
Signature of Athlete   Date

PARENTS WILL BE NOTIFIED ANY TIME A STUDENT IS EXPELLED OR SUSPENDED FROM A SPORT OR ACTIVITY.

ATHLETIC PARTICIPATION AND RELEASE FORM

______________________ ______ __________
Last Name   First Name   Grade   Home Phone

______________________ __________
Address   Town

________ ______________ __________
Birth Date   Birth Place   Work Phone

____________________ has my permission to participate in the sport of

____________________ for the __________ season. While I expect school authorities and coaches to exercise every reasonable precaution to avoid accidents and injuries, I hereby release the Audubon Board of Education and its agents, servants, teachers, coaches and any other employees, of any liability for any accidents that may occur during such participation.

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 observances of rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability or even death. I/we acknowledge that I/we have read and understand this warning.

I understand that my son or daughter will be responsible for the safe return of all athletic equipment issued to him/her, and I agree to be responsible to the Audubon Board of Education in the event of loss or damage through carelessness or improper use.

The Audubon board of Education has purchased School Time Accident Insurance to provide benefit for all students as result of accidental injury or death. This insurance provides coverage for the hours and days that school is in session and while attending school sponsored and supervised activities. This includes all Interscholastic Sports and football. Coverage is provided by Bollinger. (Please review the attached form regarding insurance coverage.)

I understand that medical information may be shared with Athletic Trainer and Coaches on an as needed basis.

______________________________________ ______________
Parent/Guardian Signature   Date

RETURN TO MRS. MIERKOWSKI IN THE BREEZEWAY OR C-102 SIGNED BY PARENT/GUARDIAN AND STUDENT*

SECTION l
GENERAL INFORMATION

2010 – 2011 School Year

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3. Smoking or other use of tobacco such as chewing tobacco.

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CODE OF ETHICS AND REGULATIONS FOR STUDENT EXTRA CURRICULAR ACTIVITIES

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____
Signature of Parent or Guardian

____
_Signature of Athlete Date

PARENTS WILL BE NOTIFIED ANY TIME A STUDENT IS EXPELLED OR SUSPENDED FROM A SPORT OR ACTIVITY.

ATHLETIC PARTICIPATION AND RELEASE FORM

_________________________________ ______ _______________
Last Name First Name Grade Home Phone

_____________________________________ _______________
Address Town

____________ ____________________________ _______________
Birth Date Birth Place Work Phone

_____________________________________ has my permission to participate in the sport of

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I understand that medical information may be shared with Athletic Trainer and Coaches on an as needed basis.

____________________________________ ____________________
Parent/Guardian Signature Date

RETURN TO MRS. MIERKOWSKI IN THE BREEZEWAY OR C-102 SIGNED BY PARENT/GUARDIAN AND STUDENT*

1161 Route 130, P.O. Box 487, Robbinsville, NJ 08691 609-259-2776 609-259-3047-Fax

NJSIAA STEROID TESTING POLICY

CONSENT TO RANDOM TESTING

In Executive Order 72, issued December 20, 2005, Governor Richard Codey directed the New Jersey Department of Education to work in conjunction with the New Jersey State Interscholastic Athletic Association (NJSIAA) to develop and implement a program of random testing for steroids, of teams and individuals qualifying for championship games.

Beginning in the Fall, 2006 sports season, any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances on the attached page, without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition. The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing.

By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that, if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

______________________________	______________________________	____________
Signature of Student-Athlete	Print Student-Athlete's Name	Date
______________________________	______________________________	____________
Signature of Parent/Guardian	Print Parent/Guardian's Name	Date

NJSIAA Banned-Drug Classes
2009 - 2010

The term "related compounds" comprises substances that are included in the class by their pharmacological action and/or chemical structure. No substance belonging to the prohibited class may be used, regardless of whether it is specifically listed as an example.

Many nutritional/dietary supplements contain NJSIAA banned substances. In addition, the U. S. Food and Drug Administration (FDA) does not strictly regulate the supplement industry; therefore purity and safety of nutritional dietary supplements cannot be guaranteed. Impure supplements may lead to a positive NJSIAA drug test. **The use of supplements is at the student-athlete's own risk.** Student-athletes should contact their physician or athletic trainer for further information.

The following is a list of banned-drug classes, with examples of banned substances under each class:

(a) Stimulants
amiphenazole
amphetamine
bemigride
benzphetamine
bromantan
caffine[1] (guorana)
chlorphentermine
cocaine
cropropamide
crothetamide
diethylpropion
dimethylamphetamine
doxapram
ephedrine
(ephedra, ma huang)
ethamivan
ethylamphetamine
fencamfamine
meclofenoxate
methamphetamine
methylenedioxymethamphetamine
(MDMA, ecstasy)
methylphenidate
nikethamide
pemoline
pentetrazol
phendimetrazine
phenmetrazine
phentermine
phenylpropanolamine (ppa)
picrotoxine
pipradol
prolintane
strychnine
synephrine
(citrus aurantium, zhi shi, bitter orange)
and related compounds

(b) Anabolic Agents
anabolic steroids
androstenediol
androstenedione
boldenone
clostebol
dehydrochlormethyl-testosterone
dehydroepiandro-sterone (DHEA)
dihydrotestosterone (DHT)
dromostanolone
epitrenbolone
fluoxymesterone
gestrinone
mesterolone
methandienone
methenolone
methyltestosterone
nandrolone
norandrostenediol
norandrostenedione
norethandrolone
oxandrolone
oxymesterone
oxymetholone
pregnelone
stanozolol
testosterone[2]
tetrahydrogestrinone
(THG)
trenbolone
and related compounds
other anabolic agents
clenbuterol

(c) Diuretics
acetazolamide
bendroflumethiazide
benzhiazide
bumetanide
chlorothiazide
chlorthalidone
ethacrynic acid
flumethiazide
furosemide
hydrochlorothiazide
hydroflumenthiazide
methyclothiazide
metolazone
polythiazide
quinethazone
spironolactone
triamterene
trichlormethiazide
and related compounds

(d) Peptide Hormones & Analogues:
corticotrophin (ACTH)
human chorionic gonadotrophin (hCG)
leutenizing hormone (LH)
growth hormone (HGH, somatotrophin)
insulin like growth hormone (IGF-1)

All the respective releasing factors of the above-mentioned substances also are banned:
erythropoietin (EPO)
darbypoetin
sermorelin

(e) Definitions of positive depends on the following:

[1] for caffine – if the concentration in urine exceeds 15 micrograms/ml

[2] for testosterone – if administration of testosterone or use of any other manipulation has the result of increasing the ratio of the total concentration of testosterone to that of epitestosterone in the urine of greater than 6:1, unless there is evidence that this ratio is due to a physiological or pathological condition.

SECTION III

ATHLETIC TRAINING PROCEDURES

Athletic Training Availability:

15 minutes before homeroom through the end of homeroom on school days. (check in the Athletic Training Office or the Nurse's Office).

- Evaluation of new injuries
- Follow-up of old injuries
- Follow-up after a doctor's appointment
- Taping for physical education classes

8th Period through the start of after school practices and games

- **Treatment, rehabilitation and taping only**

During practices and games

- First Aid
- New Injury Evaluations

After Practice

- New Injury Evaluation
- Rehabilitation
- Direction for overnight care

Weekends/Holidays/Half Days

- **It is the responsibility of the athlete to check with the Athletic Trainer to determine availability.**

- *Once the athlete begins the treatment/taping/rehabilitation process it should be continued until the athletic trainer recommends that it be discontinued. When the athlete feels that medical care is no longer needed, he/she should inform the Athletic Trainer. The Athletic Trainer will make the final decision when to terminate care in the best interest of the athlete.*

Athletes seen by or under the care of a Physician (this includes *any* type of licensed physician i.e. Dentist, Chiropractor, Dermatologist, etc.):

Any time an athlete is seen by or under the care of a physician for any illness or injury, routine care or check-up the school requires direction from that physician as to what the athlete can/cannot do. It is the athlete's responsibility to get a note from that physician stating:

- Diagnosis
- Treatment, rehabilitation, or taping that should be provided by the school's Athletic Trainer
- Physical Education Limitations (if any)
- Interscholastic athletic participation limitations
- Date of next appointment (if one is needed)
- **Notes must state whether or not athletes may participate in their sport**.

If an athlete knows that he/she is going to see a physician, a ***"Wounded Wave"*** medical information form should be taken to the physician for completion. This form is available from the Athletic Trainer's office or from the School Nurse's office.

Any correspondences from an athlete's physician should be brought to the Athletic Trainer or School Nurse as soon as the athlete returns to school. **Notes must NOT be given to the coach for clearance.**

Athletes under the care of a physician cannot return to participation in interscholastic athletics without written approval from that physician. Under the direction of the school's team physician, the Athletic Trainer or School Nurse will make the final decision as to an athlete's return to participation.

AUDUBON BOARD OF EDUCATION
350 EDGEWOOD AVENUE
AUDUBON, NJ 08106

Robert Delengowski Tel: (856) 547-7695 ext. 4104
Business Administrator/Board Secretary Fax: (856) 546-8550

STUDENT ACCIDENT INSURANCE PROVIDED BY THE AUDUBON BOARD OF EDUCATION

The Audubon Board of Education has purchased School Time Accident Insurance to provide benefits for all students as a result of accidental injury or death. This insurance provides coverage for the hours and days that school is in session and while attending school sponsored and supervised activities. This includes all Interscholastic Sports and Football. Coverage is administered by Bollinger Insurance.

INSURANCE INFORMATION

The maximum benefit is $1,000,000 and Usual and Customary benefits are provided on a full excess basis for covered expenses incurred within 18 months of the date of the accident. Out of hospital physical therapy benefits as well as orthopedic appliances will also be covered up to the Usual and Customary allowances.

Following is an example of how a full excess claim is handled:

> A student incurs medical expenses of $150 for treatment of an injury sustained during recess. The student's parents have private health insurance with Blue Cross/Blue Shield. All medical bills related to the student's injury must first be submitted to Blue Cross/Blue Shield. If Blue Cross/Blue Shield pays only $65 of the $150 charge, then the balance of $85 may be submitted to Bollinger for consideration. If the balance is eligible for payment, then Bollinger will reimburse the remaining $85.

IMPORTANT NOTE

All benefits are based upon a Usual and Customary Allowance. Any charges in excess of the Usual and Customary Allowance will be the responsibility of the student's parents. If a student's parents have private health insurance through an HMO or a Point of Service Plan, i.e. US Healthcare, HMO Blue, etc., all rules of the HMO must be followed.

CLAIM INSTRUCTIONS

In case of an accident, immediately notify the person in charge and then report to the school nurse to complete an accident report and to receive a claim form.

- The claim form must be submitted within 90 days from the date of injury.
- Treatment must begin within 90 days from the date of injury.
- Please have the Doctor complete the appropriate part on the back of the claim form and attach itemized bills showing treatment with date performed and corresponding charges. Forward bills to Bollinger Insurance, P.O. Box 706, Short Hills, NJ 07078-0706 (Phone: 1-973-467-0444).
- Please note Audubon School District on all bills and correspondence.
- All benefits will be made payable to Doctors and Hospitals involved unless paid receipts are submitted.

The Pediatric/Adult Asthma Coalition of New Jersey

"Your Pathway to Asthma Control"
PACNJ approved Plan available at
www.pacnj.org

Asthma Treatment Plan
Patient/Parent Instructions

The **PACNJ Asthma Treatment Plan** is designed to help everyone understand the steps necessary for the individual patient to achieve the goal of controlled asthma.

1. Patients/Parents/Guardians: *Before taking this form to your Health Care Provider:*
Complete the top left section with:
- Patient's name
- Patient's date of birth
- Patient's doctor's name & phone number
- Parent/Guardian's name & phone number
- An Emergency Contact person's name & phone number

2. Your Health Care Provider will:
Complete the following areas:
- The effective date of this plan
- The medicine information for the Healthy, Caution and Emergency sections
- Your Health Care Provider will check the box next to the medication and check how much and how often to take it
- Your Health Care Provider may check **"OTHER" and:**
  - ❖ **Write in asthma medications not listed on the form**
  - ❖ **Write in additional medications that will control your asthma**
  - ❖ **Write in generic medications in place of the name brand on the form**
- Together you and your Health Care Provider will decide what asthma treatment is best for you or your child to follow.

3. Patients/Parents/Guardians & Health Care Providers together:
Discuss and then complete the following areas:
- Patient's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
- Patient's asthma triggers on the right side of the form
- For Minors Only section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. Parents/Guardians: *After completing the form with your Health Care Provider:*
- Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
- Keep a copy easily available at home to help manage your child's asthma
- Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

This Asthma Treatment Plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs. Not all asthma medications are listed and the generic names are not listed.

Disclaimers:
The use of this Website/PACNJ Asthma Treatment Plan and its content is at your own risk. The content is provided on an "as is" basis. The American Lung Association of the Mid-Atlantic (ALAM-A), the Pediatric/Adult Asthma Coalition of New Jersey and all affiliates disclaim all warranties, express or implied, statutory or otherwise, including but not limited to the implied warranties or merchantability, non-infringement of third parties' rights, and fitness for a particular purpose.

ALAM-A makes no representations or warranties about the accuracy, reliability, completeness, currency, or timeliness of the content. ALAM-A makes no warranty, representation or guaranty that the information will be uninterrupted or error free or that any defects can be corrected.

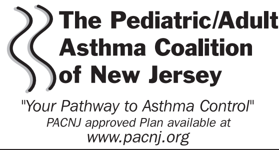
In no event shall ALAM-A be liable for any damages (including, without limitation, incidental and consequential damages, personal injury/wrongful death, lost profits, or damages resulting from data or business interruption) resulting from the use or inability to use the content of this Asthma Treatment Plan whether based on warranty, contract, tort or any other legal theory, and whether or not ALAM-A is advised of the possibility of such damages. ALAM-A and its affiliates are not liable for any claim, whatsoever, caused by your use or misuse of the Asthma Treatment Plan, nor of this website.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey, and this publication are supported by a grant from the New Jersey Department of Health and Senior Services (NJDHSS), with funds provided by the U.S. Centers for Disease Control and Prevention (USCDCP) under Cooperative Agreement 5U59EH000206-3. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NJDHSS or the USCDCP. Although this document has been funded wholly or in part by the United States Environmental Protection Agency under Agreement XA97256707-2 to the American Lung Association of New Jersey, it has not gone through the Agency's publications review process and therefore, may not necessarily reflect the views of the Agency and no official endorsement should be inferred. Information in this publication is not intended to diagnose health problems or take the place of medical advice. For asthma or any medical condition, seek medical advice from your child's or your health care professional.

AMERICAN LUNG ASSOCIATION® IN NEW JERSEY

Asthma Treatment Plan

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)



PACNJ approved Plan available at www.pacnj.org

(Please Print)

Name	Date of Birth	Effective Date

Doctor	Parent/Guardian (if applicable)	Emergency Contact
Phone	Phone	Phone

HEALTHY

Take daily medicine(s). Some metered dose inhalers may be more effective with a "spacer" – use if directed

You have *all* of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above ________

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® ☐ 100, ☐ 250, ☐ 500 __________	1 inhalation twice a day
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230________	2 puffs MDI twice a day
☐ Alvesco® ☐ 80, ☐ 160 ________________	☐ 1, ☐ 2 puffs MDI twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220 ______	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220___________	2 puffs MDI twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250_____	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180_______	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® ☐ 0.25, ☐ 0.5, ☐ 1.0 __	1 unit nebulized ☐ once or ☐ twice a day
☐ Qvar® ☐ 40, ☐ 80 ____________________	☐ 1, ☐ 2 puffs MDI twice a day
☐ Singulair ☐ 4, ☐ 5, ☐ 10 mg___________	1 tablet daily
☐ Symbicort® ☐ 80, ☐ 160_______________	☐ 1, ☐ 2 puffs MDI twice a day
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take this medicine_____________________ ____minutes before exercise.

CAUTION

Continue daily medicine(s) and add fast-acting medicine(s).

You have *any* of these:

- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:__________

And/or Peak flow from______ to______

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Accuneb® ☐ 0.63, ☐ 1.25 mg _________	1 unit nebulized every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg ___________	1 unit nebulized every 4 hours as needed
☐ Albuterol ☐ Pro-Air ☐ Proventil® _______	2 puffs MDI every 4 hours as needed
☐ Ventolin® ☐ Maxair ☐ Xopenex® _______	2 puffs MDI every 4 hours as needed
☐ Xopenex® ☐ 0.31, ☐ 0.63, ☐ 1.25 mg __	1 unit nebulized every 4 hours as needed
☐ Increase the dose of, or add:	
☐ Other	

➡ **If fast-acting medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY

Your asthma is getting worse fast:

- Fast-acting medicine did not help within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue

And/or Peak flow below ________

Take these medicines NOW and call 911.

Asthma can be a life-threatening illness. Do not wait!

- ☐ Accuneb® ☐ 0.63, ☐ 1.25 mg _________1 unit nebulized every 20 minutes
- ☐ Albuterol ☐ 1.25, ☐ 2.5 mg ___________1 unit nebulized every 20 minutes
- ☐ Albuterol ☐ Pro-Air ☐ Proventil® _______2 puffs MDI every 20 minutes
- ☐ Ventolin® ☐ Maxair ☐ Xopenex® _______2 puffs MDI every 20 minutes
- ☐ Xopenex® ☐ 0.31, ☐ 0.63, ☐ 1.25 mg __1 unit nebulized every 20 minutes
- ☐ Other

Triggers

Check all items that trigger patient's asthma:

- ❏ Chalk dust
- ❏ Cigarette Smoke & second hand smoke
- ❏ Colds/Flu
- ❏ Dust mites, dust, stuffed animals, carpet
- ❏ Exercise
- ❏ Mold
- ❏ Ozone alert days
- ❏ Pests - rodents & cockroaches
- ❏ Pets - animal dander
- ❏ Plants, flowers, cut grass, pollen
- ❏ Strong odors, perfumes, cleaning products, scented products
- ❏ Sudden temperature change
- ❏ Wood Smoke
- ❏ Foods: ____________ ____________ ____________
- ❏ Other: ____________ ____________ ____________ ____________ ____________

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

The Pediatric/Adult Asthma Coalition of New Jersey, sponsored by the American Lung Association of New Jersey, and this publication are supported by a grant from the New Jersey Department of Health and Senior Services (NJDHSS), with funds provided by the U.S. Centers for Disease Control and Prevention (USCDCP) under Cooperative Agreement 5U59EH000206-3. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NJDHSS or the USCDCP.

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REVISED MAY 2009

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www.pacnj.org

FOR MINORS ONLY:

☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE______________________________ DATE_________

PARENT/GUARDIAN SIGNATURE______________________________

PHYSICIAN STAMP

Make a copy for patient and for physician file. For children under 18, send original to school nurse or child care provider.

THIS FORM MUST BE COMPLETED EACH SEASON

New Jersey Department of Education
ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the parent and student and reviewed by examining provider
Part B: PHYSICAL EVALUATION FORM-Completed by examining licensed provider with MD, DO, APN or PA

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date:_____________________ **Date of Last Sports Physical:** ___________________________

Student's Name: ____________________________________ Sex: M F (circle one) Age: ____ Grade: ________

Date of Birth: ____/___/_______ School: _____________________________ District: ________________________

Sport(s): ____ Home Phone: (_____) ___________

Provider Name (Medical Home): _________________________________ Phone: ________________________ Fax: ____________

EMERGENCY CONTACT INFORMATION

Name of parent/guardian: ___________________________________ Relationship to student: _______________________________

Phone (work): ______________________ Phone (home):________________________________ Phone (cell): __________________

Additional emergency contact: _____________________________ Relationship to student: _______________________________

Phone (work): ______________________ Phone (home):________________________________ Phone (cell): __________________

Directions: Please answer the following questions about the student's medical history by CIRCLING the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. **Have you ever had, or do you currently have:**
   - a. Restriction from sports for a health related problem? Y / N / Don't Know
   - b. An injury or illness since your last exam? Y / N / Don't Know
   - c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know
     - (1.) An inhaler or other prescription medicine to control asthma? Y / N / Don't Know
   - d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know
   - e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
   - f. Any **allergies** to medications? **Y / N / Don't Know**
   - g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't Know
     - (1.) If yes, check type of reaction:

       ☐ Rash ☐ Hives ☐ Breathing or other anaphylactic reaction
     - (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) Y / N / Don't Know
   - h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know
   - i. A blood relative who died before age 50? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

____
____
____
____
____

List all medications here:

Medication Name	Dosage	Frequency

 Use of this form is required by N.J.A.C. 6A:16-***Programs to Support Student Development***

2. **Have you ever had, or do you currently have, any of the following *head-related* conditions:**

a. Concussion or head injury (including "bell rung" or a "ding")?	Y / N / Don't Know
b. Memory loss?	Y / N / Don't Know
c. Knocked out?	Y / N / Don't Know
c. A seizure?	Y / N / Don't Know
d. Frequent or severe headaches (With or without exercise)?	Y / N / Don't Know
e. Fuzzy or blurry vision	Y / N / Don't Know
f. Sensitivity to light/noise	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

____
____
____

3. **Have you ever had, or do you currently have, any of the following *heart-related* conditions:**

a. Restriction from sports for heart problems?	Y / N / Don't Know
b. Chest pain or discomfort?	Y / N / Don't Know
c. Heart murmur?	Y / N / Don't Know
d. High blood pressure?	Y / N / Don't Know
e. Elevated cholesterol level?	Y / N / Don't Know
f. Heart infection?	Y / N / Don't Know
g. Dizziness or passing out during or after exercise without known cause?	Y / N / Don't Know
h. Has a provider ever ordered a heart test (EKG, echocardiogram, stress test, Holter monitor)?	Y / N / Don't Know
i. Racing or skipped heartbeats?	Y / N / Don't Know
j. Unexplained difficulty breathing or fatigue during exercise?	Y / N / Don't Know
k. Any family member (blood relative):	
(1.) Under age 50 with a heart condition?	Y / N / Don't Know
(2.) With Marfan Syndrome?	Y / N / Don't Know
(3.) Died of a heart problem before age 50? If yes, at what age? ________________	Y / N / Don't Know
(4.) Died with no known reason?	Y / N / Don't Know
(5.) Died while exercising? If yes, was it during or after? (Circle one.)	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

____
____
____

4. **Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat conditions:***

a. Vision problems?	Y / N / Don't Know
(1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.)	Y / N / Don't Know
b. Hearing loss or problems?	Y / N / Don't Know
(1.) Wear hearing aides or implants?	Y / N / Don't Know
c. Nasal fractures or frequent nose bleeds?	Y / N / Don't Know
d. Wear braces, retainer or protective mouth gear?	Y / N / Don't Know
e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)?	Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

____
____
____

5. **Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic conditions*:**

a. Numbness, a "burner", "stinger" or pinched nerve?	Y / N / Don't Know
b. A sprain?	Y / N / Don't Know
c. A strain?	Y / N / Don't Know
d. Swelling or pain in muscles, tendons, bones or joints?	Y / N / Don't Know
e. Dislocated joint(s)?	Y / N / Don't Know
f. Upper or lower back pain?	Y / N / Don't Know
g. Fracture(s), stress fracture(s), or broken bone(s)?	Y / N / Don't Know
h. Do you wear any protective braces or equipment?	Y / N / Don't Know

Explain all (yes) answers here (include relevant dates):

____
____
____

6. **Have you ever had or do you currently have any of the following *general or exercise related conditions*:**

a. Difficulty breathing?

(1.) During exercise? — Y / N / Don't Know

(2.) After running one mile? — Y / N / Don't Know

(3.) Coughing, wheezing or shortness of breath in weather changes? — Y / N / Don't Know

(4.) Exercise-induced asthma? — Y / N / Don't Know

i. Controlled with medication? (specify ___________________________) — Y / N / Don't Know

ii. Experience dizziness, passing out or fainting? — Y / N / Don't Know

b. Viral infections (e.g. mono, hepatitis, coxsackie virus)? — Y / N / Don't Know

c. Become tired more quickly than others? — Y / N / Don't Know

d. Any of the following skin conditions:

(1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts? — Y / N / Don't Know

(2.) Sun sensitivity? — Y / N / Don't Know

e. Weight gain/loss (of 10 pounds or more)? — Y / N / Don't Know

(1.) Do you want to weigh more or less than you do now? — Y / N / Don't Know

f. Ever had feelings of depression? — Y / N / Don't Know

g. Heat-related problems (dehydration, dizziness, fatigue, headache)? — Y / N / Don't Know

(1.) Heat exhaustion (cool, clammy, damp skin)? — Y / N / Don't Know

(2.) Heat stroke (hot, red, dry skin)? — Y / N / Don't Know

(3.) Muscle cramps? — Y / N / Don't Know

h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? — Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

____

____

____

7. **Females only:**

Age of onset of menstruation:______

How many menstrual periods in the last twelve (12) months? ________

How many periods missed in the last twelve (12) months? ________

8. **Males only:**

Have you had any swelling or pain in your testicles or groin? — Y / N / Don't Know

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

____

Signature, Parent/Guardian or Student Age 18

____

Date of Signature:

THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.

THIS FORM MUST BE COMPLETED EACH SEASON

THIS MUST BE COMPLETED IF THERE IS NO CURRENT PHYSICAL ON FILE. A PHYSICAL IS GOOD 364 DAYS FROM THE DATE OF THE EXAM.

ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

Part B: Physical Evaluation Form

(Completed by the examining licensed provider MD, DO, APN or PA)

-STUDENT INFORMATION-

Student's Name: ____________________________________ Sport(s): ____
Sex: M F (circle one) Age: ________ Grade: _____________ Date of Birth: ____
Address: ____
City/State/Zip:____ Home Phone: ____
School: ____ District: ____
Parent/Guardian's Full Name: ____

- EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

If conducted by school physician check here ☐

Name: _________________________________ Phone: ___________________________ Fax: __________________

Address:________________________________ City/State/Zip:____

- FINDINGS OF PHYSICAL EVALUATION -

Height: _________ Weight: _________ Blood Pressure: ______/_______ Pulse: _____bpm.

Vision: R 20/____ L 20/ ____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS			
General Appearance	YES				
Head/Neck	YES				
Eyes/Sclera/Pupils	YES				
Ears	YES				
Gross Hearing	YES				
Nose/Mouth/Throat	YES				
Lymph Glands	YES				
Cardiovascular	YES				
Heart Rate	YES				
Rhythm	YES				
Murmur	ABSENT				
If murmur present		Standing makes it:	Louder	Softer	No Change
		Squatting makes it:	Louder	Softer	No Change
		Valsalva makes it:	Louder	Softer	No Change
Femoral Pulses	YES				
Lungs: Auscultation/Percussion	YES				
Chest Contour	YES				
Skin	YES				
Abdomen (liver, spleen, masses)	YES				
Assessment of physical maturation or Tanner Scale	YES				
Testicular Exam (Males Only)	YES				
Neck/Back/Spine:	YES				
Range of Motion	YES				
Scoliosis	ABSENT				
Upper Extremities: (ROM, Strength, Stability)	YES				
Lower Extremities: (ROM, Strength, Stability)	YES				
Neurological: Balance & Coordination	YES				
Hernia	ABSENT				
Evidence of Marfan Syndrome	ABSENT				

Use of this form is required by N.J.A.C. 6A:16-***Programs to Support Student Development***

Most recent immunizations and dates administered:
____
____
____

Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Additional observations:
____
____
____
____

General Diagnosis: ____
____
____

General Recommendations:
____
____

THE HISTORY PREPARED BY THE PARENT/STUDENT MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE PHYSICAL EXAMINATION.

CLEARANCES: This section is completed by the examining healthcare provider.

After examining the student and reviewing the medical history the student is:

☐ **A.** **Cleared** for participation in **all** sports without restrictions.

☐ **B.** **Not cleared** for participation in **any** sport until evaluation/treatment of:

____

☐ **C.** **Cleared for limited participation** in the following types of sports only. Please see below for sport classifications. CHECK ALL THAT APPLY

___ CONTACT/COLLISION
___ LIMITED CONTACT
___ NON-CONTACT/STRENUOUS
___ NON-CONTACT/NON-STRENUOUS

Limitations due to: ____

____

NOTES TO THE EXAMINING PROVIDER

Conditions requiring clearance before sports participation include, but are not limited to the following:

Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly, Splenomegaly; Malignancy; Seizure Disorder; Marfan's Syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT			
Contact/Collision	**Limited Contact**	**Non-Contact**	
		Strenuous	**Non-strenuous**
Basketball	Baseball	Discus	Bowling
Diving	Cheerleading	Javelin	Golf
Field Hockey	Fencing	Shot put	
Football	High Jump	Rowing	
Ice Hockey	Pole vault	Running/Cross Country	
Lacrosse	Gymnastics	Strength Training	
Soccer	Skiing	Swimming	
Wrestling	Softball	Tennis	
	Volleyball	Track	

Effects of physiologic maneuvers on heart sounds

Standing
- Increases murmur of HCM
- Decreases murmur of AS, MR
- MVP click occurs earlier in systole

Squatting
- Increases murmur of AS, MR, AI
- Decreases murmur of MCH
- MVP click delayed

Valsalva
- Increases murmur of HCM
- Decreases murmur of AS, MR
- MVP click occurs earlier in systole

HCM: Hypertrophic Cardio Myopathy
AS: Aortic Stenosis
AI: Aortic Insufficiency
MR: Mitral Regugitation
MVP: Mitral Valve Prolapse

Physical Stigmata of Marfan's Syndrome

Kyphosis
High arched palate
Pectus excavatum
Arachnodactyly
Arm span > height 1.05:1 or greater
Mitral Valve Prolapse
Aortic Insufficiency
Myopia
Lenticular dislocation

DOCTOR'S SIGNATURE
REQUIRED ON NEXT PAGE

DOCTORS MUST REVIEW HEALTH HISTORY
QUESTIONNAIRE AT TIME OF PHYSICAL

HISTORY REVIEWED AND STUDENT EXAMINED BY: Physician's/Provider's Stamp:

☐ Primary Care Provider
☐ School Physician Provider
☐ License Type:
- ☐ MD/DO
- ☐ APN
- ☐ PA

PHYSICIAN'S/PROVIDER'S SIGNATURE: ____

Today's Date: _____________ Date of Exam: _____________

RESERVED FOR SCHOOL DISTRICT USE

NOTE: *N.J.A.C. 6A:16-2.2* requires the school physician to provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this physical evaluation. This evaluation and the notification letter become part of the student's school health record.

History and Physical Reviewed By: _________________________________ Date: ______________

Title of Reviewer (please check one): ☐ School Nurse ☐ School Physician

Medical Eligibility Notification Sent to Parent/Guardian by School Physician _____________________
Date

☐ Letter of notification is attached.

OR

Parent notification indicates that:

☐ Participation Approved without limitations.

☐ Participation Approved with limitations pending evaluation.

☐ Participation NOT Approved

Reason(s) for Disapproval: ____

____

This form must be completed each season

Emergency Card

Name ____________ Sport ____________

Home Phone number ____________ Grade ____________

Parent Emergency Number (ex. Work/Cell) ____________

Emergency Contact ____________ Phone ____________

Emergency Contact ____________ Phone ____________

Family Medical Insurance Information:

Carrier ________ Group________ Policy #____________

Allergies (list):____________ Health Concerns:____________

Emergency room physicians and private physicians will usually treat children only if a parent/guardian is present. In an emergency, when neither parent/guardian is available, most physicians will give immediate care if written permission is given.

I give permission for my child to be given emergency care until I can be contacted.

Hospital preference (if possible) ____________

Signature of parent/guardian ____________ Date ____________

This form must be completed each season

Emergency Card

Name ____________ Sport ____________

Home Phone number ____________ Grade ____________

Parent Emergency Number (ex. Work/Cell) ____________

Emergency Contact ____________ Phone ____________

Emergency Contact ____________ Phone ____________

Family Medical Insurance Information:

Carrier ________ Group________ Policy #____________

Allergies (list):____________ Health Concerns:____________

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Signature of parent/guardian ____________ Date ____________

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Carrier ________ Group________ Policy #____________

Allergies (list):____________ Health Concerns:____________

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Emergency Contact ____________ Phone ____________

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Carrier ________ Group________ Policy #____________

Allergies (list):____________ Health Concerns:____________

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I give permission for my child to be given emergency care until I can be contacted.

Hospital preference (if possible) ____________

Signature of parent/guardian ____________ Date ____________