RIDGEFIELD PARK PUBLIC SCHOOLS
712 Lincoln Avenue, Ridgefield Park, NJ 07660
Tel: 201-807-2640 // www.rpps.net

Bienvenido al Distrito de Escuelas Públicas de Ridgefield Park

TENGA EN CUENTA:

La siguiente es una lista de documentos que deben presentarse para inscribir a un estudiante en el Sistema de Escuelas Públicas de Ridgefield Park. Todos los elementos enumerados a continuación **DEBEN SER ENVIADOS** o su registro no será procesado.

- ☐ Solicitud de inscripción
- ☐ nacimiento
- ☐ Identificación del padre/tutor
- ☐ Afirmación de residencia
  a. **Propia:** escritura, registros de impuestos sobre la propiedad o estado de cuenta de la hipoteca
  b. **Renta:** contrato de arrendamiento actual con la información de contacto del arrendador O Declaración jurada del arrendador completada y notariada con la información de contacto del arrendador
  c. **Factura de servicios públicos:** debe estar al día.
- ☐ Tarjeta de transferencia del distrito escolar anterior.
- ☐ Estudiantes de educación especial: si su hijo tiene un IEP o 504, debe incluir el IEP más reciente del distrito escolar actual.
- ☐ Registros médicos
  a. **para estudiantes de primaria (K-6)**: formulario de registro de salud universal completado por un médico junto con los registros de vacunación.
  b. **Estudiantes de secundaria (7-12)**: formulario de historial de evaluación física previa a la participación junto con los registros de vacunación.

INFORMACIÓN ADICIONAL REQUERIDA:

Los estudiantes de secundaria deben proporcionar registros académicos (transcripciones) de la escuela anterior que muestren el trabajo del curso y los créditos completados. Si el estudiante ingresa al 9° grado, debe mostrar prueba de que el estudiante ha completado el 8° grado. Si viene de una escuela de Nueva Jersey, proporcione los puntajes de NJASK y HSPA si están disponibles.

Se debe presentar la documentación de custodia o tutela del tribunal suplente del juzgado del condado de Bergen cuando el estudiante no vive con los padres.

Una vez que haya completado la solicitud de registro en línea, el distrito se comunicará con usted.

Si tiene alguna pregunta antes o después de completar el registro en línea, comuníquese con kthompson@rpschools.net.

Todos los paquetes de registro serán revisados dentro de las 48 horas posteriores a la confirmación.

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FECHA:_____ **GRADO**:_____

INFORMACIÓN DEL ESTUDIANTE:

APELLIDO: _____

PRIMER NOMBRE: _____ **SEGUNDO NOMBRE:** _____

INFORMACIÓN DE NACIMIENTO: SI NACIÓ EN LOS EE. UU.

FECHA DE NACIMIENTO: _____ **CIUDAD NATAL:** _____

ESTADO DE NACIMIENTO: _____

INFORMACIÓN DE NACIMIENTO: SI NACIÓ FUERA DE LOS EE. UU.

FECHA DE NACIMIENTO: _____ **CIUDAD/PAÍS DE NACIMIENTO:** _____

FECHA DE ENTRADA EN NOSOTROS: _____

GÉNERO:	**ETNIA**: SE REQUIEREN DATOS PARA TODAS LAS ESCUELAS PÚBLICAS DE NJ	
☐ HOMBRE	☐ HISPANO O LATINO	
☐ MUJER	☐ NO HISPANO O LATINO	
☐ NO/BINARIO NO DESIGNADO	**RAZA**:	
SEXO DE NACIMIENTO:	☐ BLANCO	☐ ASIÁTICO
☐ MASCULINO	☐ NEGRO (AFROAMERICANO)	☐ NATIVO DE HAWAIANO/ISL DEL PACÍFICO
☐ MUJER	☐ INDIA AMERICANA/ALASKA	☐ OTRO: _____

RESIDENCIA LEGAL:

☐ PROPIO ☐ ALQUILA ☐ OTRO _____

DIRECCIÓN: _____ **APT #:** _____

CIUDAD: _____ **ESTADO:** _____ **CÓDIGO POSTAL:** _____

ALGUNA VEZ HA SIDO EVALUADO SU HIJO PARA SERVICIOS DE EDUCACIÓN ESPECIAL?

☐ SÍ ☐ NO

☐ IEP	☐ IFSP	☐ ISP	☐ 504	☐ EVALUACIONES
☐ NOTA DEL MÉDICO		☐ CORRESPONDENCIA DEL MAESTRO/ESCUELA		☐ OTRO: POR FAVOR

PROPORCIONE INFORMACIÓN CONEXIÓN MILITAR:

☐ ACTIVO – DEPENDIENTE DE UN MIEMBRO ACTIVO A TIEMPO COMPLETO DE LAS FUERZAS ARMADAS (EJÉRCITO, MARINA, MARINA, FUERZA AÉREA O GUARDACOSTAS
☐ NO CONEXIÓN MILITAR

INFORMACIÓN DE LA ESCUELA ANTERIOR:

NOMBRE:	
CIUDAD/ESTADO:	
NIVEL DE GRADO:	**FECHAS DE ASISTENCIA:**

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FECHA:_____ **NIVEL DE GRADO**:_____

NOMBRE DEL ESTUDIANTE: _____

INFORMACIÓN DEL PADRE/TUTOR:

TUTOR 1:

NOMBRE:		**RELACIÓN:**
DIRECCIÓN:		**APT #:**
TELÉFONO CELULAR:	**TELÉFONO CELULAR**	**CASA:**
CORREO ELECTRÓNICO:		

TUTOR 2:

NOMBRE:		**RELACIÓN:**
DIRECCIÓN:		**APT #:**
TELÉFONO CELULAR:	**TELÉFONO CELULAR:**	**CASA TELÉFONO:**
CORREO ELECTRÓNICO:		

HERMANOS QUE ASISTEN AL DISTRITO ESCOLAR DE RIDGEFIELD PARK:

NOMBRE: **ESCUELA**: **POR FAVOR CIRCULAR UNO**
GRADO:

	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSEVELT / GRANT / LINCOLN	

RECONOCIMIENTO:

Certifico que la información proporcionada por mí es verdadera, soy consciente de que si alguna de las declaraciones anteriores hechas por mí es falsa, estoy sujeto a castigo bajo la ley y puede resultar en responsabilidad financiera por asistir a la escuela.

NOMBRE EN LETRA DE IMPRENTA:

_____

FIRMA: _____ FECHA: _____

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FORMULARIO DE SOLICITUD DE REGISTROS ACADÉMICOS

Grant School	Lincoln School	Roosevelt School	RPJRSRHS	Office of Special Servicios
104 Henry Street	712 Lincoln Avenue	508 Teaneck Road	One Ozzie Nelson Drive	98 Central Avenue
201-641-0441	201-994-1830	201-440-0808	201-440-1440	201-807-2650

Fecha: _____

El niño nombrado a continuación se ha inscrito en una de nuestras escuelas. El padre/tutor ha autorizado que los siguientes registros deben enviarse a la escuela marcada con un círculo lo antes posible:

- ☐ Académico (incluyendo boleta de calificaciones, expediente académico, puntajes de exámenes estandarizados, IEP)
- ☐ Asistencia
- ☐ Disciplinario
- ☐ Médico/Salud
- ☐ Confidencial

Nombre completo de la escuela anterior: _____
Dirección: _____
Ciudad/Estado/Código postal: _____
teléfono: _____
Número de fax: _____
Correo electrónico de contacto: _____
Gracias por su cooperación.

Por la presente doy permiso para divulgar todos los
registros escolares académicos, de asistencia, de salud, disciplinarios y confidenciales a la escuela marcada con un círculo arriba para:

Nombre del niño: _____

Grado actual: _____

Nombre del padre/tutor (letra de imprenta): _____

Firma del padre/tutor: _____

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INICIATIVA DE EDUCACIÓN ESPECIAL DE MEDICAID (SEMI)

DISTRITO ESCOLAR DE RIDGEFIELD PARK:

Nuestro distrito escolar participa en el programa Iniciativa de Medicaid de Educación Especial (SEMI) que permite a los distritos escolares facturar a Medicaid por los servicios que se brindan a los estudiantes.

De acuerdo con la Ley de Privacidad y Derechos Educativos de la Familia, 34 CFR §99.30 y la Sección 617 de IDEA Parte B, los requisitos de consentimiento en 34 CFR §300.622 requieren un consentimiento único antes de acceder a los Beneficios públicos.

Este consentimiento establece que la información de identificación personal de su hijo, como los registros de los estudiantes o la información sobre los servicios prestados a su hijo, incluidas las evaluaciones y los servicios especificados en el Programa de Educación Individualizado (IEP) de mi hijo (terapia ocupacional, fisioterapia, terapia del habla, asesoramiento psicológico , audiología, enfermería y transporte especializado) pueden divulgarse a Medicaid y al Departamento del Tesoro con el fin de recibir el reembolso de Medicaid en el Distrito escolar.

Como padre/tutor del niño mencionado a continuación, doy permiso para divulgar información como se describe anteriormente y entiendo y acepto que Medicaid puede acceder a los beneficios públicos o al seguro público de mi hijo o míos para pagar la educación especial o los servicios relacionados según la Parte 300 (servicios bajo el IDEA). Entiendo que el distrito escolar aún debe brindar servicios a mi hijo de conformidad con su IEP, independientemente de mi estado de elegibilidad para Medicaid o mi voluntad de dar mi consentimiento para la facturación de SEMI

. Entiendo que la facturación de estos servicios por parte del distrito no afecta mi capacidad. para acceder a estos servicios para mi hijo fuera del entorno escolar, ni mi familia incurrirá en ningún costo, incluidos copagos, deducibles, pérdida de elegibilidad o impacto en los beneficios de por vida.

Nombre del niño: _____

Fecha de nacimiento: _____

Firma del padre/tutor: _____

Fecha: _____

Doy mi consentimiento para facturar por SEMI:

- ☐ SÍ
- ☐ NO

Este consentimiento se puede revocar en cualquier momento comunicándose con el Administrador de casos de su hijo o con el administrador de la escuela de su hijo , por escrito.

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Encuesta sobre el idioma que se habla en casa

Objetivo: la encuesta sobre el idioma que se habla en casa se utiliza únicamente con el fin de ofrecer servicios educativos adecuados (de acuerdo con el capítulo 1 de la Herramienta EL del Departamento de Educación de EE. UU.). Esta encuesta es el primero de los tres pasos para determinar si un estudiante es elegible para ser identificado como estudiante de inglés (ELL, por sus siglas en inglés). En este sentido, se entiende por "Casa" el lugar de residencia actual del estudiante.

Información del estudiante:

Nombre del estudiante: _____

Fecha de nacimiento (AAAA/MM/DD): _____

Dirección actual: _____

Preguntas de la encuesta:

1.) Liste todos los idiomas que se hablan en la casa del estudiante.

_____

2.) ¿El primer idioma hablado por el estudiante fue un idioma distinto del inglés?

_____ No _____Sí

3.) ¿El estudiante habla o entiende un idioma distinto del inglés?

_____ No _____Sí

4.) Cuando se relaciona con otras personas en casa (por ejemplo: padres, encargados, hermanos), ¿el estudiante entiende o habla en un idioma distinto del inglés la mayor parte del tiempo?

_____ No _____Sí

5.) Cuando se relaciona con otras personas fuera de casa (por ejemplo, amigos, cuidadores), ¿el estudiante entiende o habla en un idioma distinto del inglés la mayor parte del tiempo?

_____ No _____Sí

Updated: June 30, 2021

DATE: _____

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DATE: _____

ALLERGY RECORD FORM

CHILD'S NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____/_____/_____ **AGE:** _____

If your child has **NO** allergies/reactions please check here ☐ and sign below.

ITEM	YES	NO	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN
DAIRY PRODUCTS					
EGGS					
PEANUTS					
OTHER FOODS PLEASE LIST BELOW					
BEES					
OTHER ANIMALS PLEASE LIST BELOW					
PENICILLIN					
ERYTHROMYCIN					
OTHER MEDS PLEASE LIST BELOW					
SEASONAL ALLERGIES					
OTHER ALLERGIES PLEASE LIST BELOW					

ADDITIONAL INFORMATION

OTHER FOOD:

FOOD	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN

OTHER ANIMALS:

ANIMAL	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN

OTHER MEDICATION:

MEDICATION	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN

OTHER ALLERGIES:

ALLERGIES	TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO CHILD: _____

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DATE: _____

MEDICAL HISTORY FORM

CHILD'S NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____/_____/_____ **AGE: _____**

Please complete the child's health history below.

DIAGNOSIS	YES	NO	DATE OF DIAGNOSIS	TREATMENT AND/OR RESTRICTIONS
ASTHMA				
BLOOD DISORDER				
CHICKEN POX				
DIABETES				
HEAD INJURY				
HEART PROBLEM				
SEIZURE				
SKIN CONDITION				
SPEECH/LANGUAGE				
URINARY PROBLEM				
VISION/GLASSES				

Current Medications: Please include the name of the medicine, the dosage, time, and reason for use.

NAME OF MEDICINE	DOSAGE	TIME	REASON

Hospitalizations for illness or surgery: Please include diagnosis and year.

HOSPITALIZATION REASON	DIAGNOSIS	YEAR

I GIVE MY PERMISSION FOR THIS INFORMATION TO BE SHARED WITH APPROPRIATE SCHOOL STAFF.

PARENT/GUARDIAN NAME:_____

PARENT/GUARDIAN SIGNATURE: _____

RELATIONSHIP TO CHILD: _____

DATE: _____

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DATE: _____

MEDICATION FORM

CHILD'S NAME: _____
LAST FIRST MIDDLE

DATE OF BIRTH: _____/_____/_____ **AGE:** _____

PARENT/GUARDIAN NAME: _____

RELATIONSHIP TO CHILD: _____

A child must not bring to school any prescribed or over-the-counter medication...not one single dose! Any such products must be brought to the school nurse by a parent/guardian with directions for use from a physician. Only a a school nurse may administer the medication.

By my signature, I certify that my child does not need to take any prescribed or over-the-counter medication during the school day.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

There are few exceptions to this rule:
Permission may be granted to your child for self-administration of medication for asthma or other potentially life threatening conditions if the school receives written permission from a parent/guardian and authorization by a physician. Even in this case, we may require that the medication be self-administered in the presence of the school nurse.

By my signature below I give permission for my child to self-administer the medication indicated by the physician. I understand that Ridgefield Park Public Schools shall incur no liability as a result of any injury arising from the self-administration of medication by my child and I shall indemnify and hold harmless the Ridgefield Park Board of Education and its employees and agent against any claims arising as a result of the self administration of medication by my child.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO CHILD: _____

TO BE COMPLETED BY PHYSICIAN'S OFFICE:

Diagnosis	Name of Medication	Form of Medication	Dose	Time	How soon the dose can be repeated	List of significant side effects	Length of time this treatment is recommended

☐ **The above mentioned child has asthma and/or other life threatening condition and has been instructed in and is capable of self-administering the medication noted above.**

Physician's Signature and Stamp: **PLACE STAMP HERE**

Physician's Name: _____

SIGNATURE: _____

ADDRESS: _____

_____

TELEPHONE: _____

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

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

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

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

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ 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	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ 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	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

HE0503 9-2681/0410

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

Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	**No**
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.

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

Explain "yes" answers here

_____

_____

_____

_____

_____

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

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

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?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

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

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]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 _____

HE0503 9-2681/0410

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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