Welcome to the Ridgefield Park Public School District

PLEASE NOTE:

The following is a list of documents that must be presented in order to enroll a student in the Ridgefield Park Public School System. All items listed below **MUST BE SUBMITTED** or your registration will not be processed.

☐ Application for Enrollment
☐ Birth Certificate
☐ Parent/Guardian ID
☐ Affirmation of Residency
a. Own - Deed, Property Tax Records, and/or Mortgage Statement
b. Rent - Current Lease with Landlord's contact information OR Landlord Affidavit completed
and notarized with Landlord's contact information
c. Utility Bill - Must be current.
☐ Transfer Card from the previous school district.
☐ Special Education Students: If your child has an IEP or 504 you must include the most recent
IEP from the current school district.
☐ Medical Records
a. Elementary Students (K-6): Universal Health Record Form completed by a physician
along with immunization records.
h High Cabool Students (7.12), Drangutiaination Dhysical Evaluation History Form along

- b. **High School Students (7-12)**: Preparticipation Physical Evaluation History Form along with immunization records.

ADDITIONAL INFORMATION REQUIRED:

High School students must provide academic records (transcripts) from the previous school showing course work and credits completed. If the student is entering the 9th grade, you must show proof that the student has completed the 8th grade. If coming from a New Jersey school, please provide NJASK and HSPA scores if available.

Custody or Guardianship paperwork from the Bergen County Courthouse Surrogate Court must be presented when a student is not living with the parent.

Once you have completed the <u>online registration application</u> you will be contacted by the district.

Should you have any questions prior to or after completing the online registration please contact kthompson@rpschools.net.

All registration packages will be reviewed within 48 hours of confirmation.

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DATE:	1011 201 001 2010 // WWW.ippo.iii	GRADE LEVEL:	
STUDENT INFORMATION:			
LAST NAME:			
FIRST NAME:	MIDDLE	NAME:	
BIRTH INFORMATION: IF BORN IN	THE US		
DATE OF BIRTH:	BIRTH CITY:	BIRTH STATE:	
BIRTH INFORMATION: IF BORN O	UTSIDE THE US		
DATE OF BIRTH:	BIRTH CITY/COUNTRY:	· · · · · · · · · · · · · · · · · · ·	
DATE OF ENTRY IN U.S.:			
GENDER:	ETHNICITY: DATA IS REQUIRED FOR ALL N	J PUBLIC SCHOOLS	
☐ MALE	☐ HISPANIC OR LATINO		
☐ FEMALE	☐ NOT HISPANIC OR LATINO		
☐ NON/BINARY UNDESIGNATED	RACE:		
BIRTH GENDER:	☐ WHITE	ASIAN	
☐ MALE	BLACK (AFRICAN AMERICAN)	☐ NATIVE HAWAIIAN/PACIFIC ISLANDER	
FEMALE	AMERICAN INDIAN/ALASKAN	OTHER:	
LEGAL DESIDENCE:			
<u>LEGAL RESIDENCE</u> :			
☐ OWN ☐ RENT	☐ OTHER		
ADDRESS:		APT #:	
	STATE:		
	ALUATED FOR SPECIAL EDUCATION SERV		
_	TECHTED I ON OF LOIME EDUCATION SERV	<u></u> .	
YES NO			
☐ IEP ☐ IFSP	☐ ISP ☐ 504	EVALUATIONS	
DOCTOR'S NOTE	☐ TEACHER/SCHOOL CORRESPONDEN	CE OTHER: PLEASE SUPPLY	
	'	-	
MILITARY CONNECTED INFORMAT	<u>'ION</u> :		
ACTIVE DUTY - DEPENDENT OF COAST GUARD NOT MILITARY CONNECTED	AN ACTIVE FULL TIME MEMBER OF THE ARMED FO	PRCES (ARMY, NAVY, MARINE, AIR FORCE OR	
PREVIOUS SCHOOL INFORMATION	<u> </u>		
NAME:			
CITY/STATE:			
GRADE LEVEL:	DATES ATTENDED		

DATE:		GRADE LEVEL:	····
STUDENT NAME:			
PARENT/GUARDIAN INFORMATION:			
GUARDIAN 1:			
		T	
NAME:		RELATIONSHIP:	
ADDRESS:		<u>APT #:</u>	
CELL PHONE:	ELL PHONE CARRIER:	HOME PHONE:	
EMAIL:			
GUARDIAN 2:			
NAME:		RELATIONSHIP:	
ADDRESS:		APT #:	
CELL PHONE:	ELL PHONE CARRIER:	HOME PHONE:	
EMAIL:			
SIBLING(S) ATTENDING THE RIDGEFIEL	PARK SCHOOL DISTRICT:		
NAME:	SCHOOL: PLEASE CIRC	CLE ONE	GRADE
		VELT / GRANT / LINCOLN	<u> </u>
	RP JR/SR HS / ROOSE	VELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSE	VELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSE	VELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSE	VELT / GRANT / LINCOLN	
	RP JR/SR HS / ROOSE	VELT / GRANT / LINCOLN	
ACKNOWLEDGEMENT: I certify that the information made by	ne is true, I am aware that if any o	f the foregoing statements	
me are false, I am subject to punishr attendance.	ent under the law and may result i	n financial responsibility for	school
PRINT NAME:			

AFFIRMATION OF RESIDENCY

DATE:			
I, HEREBY CERTIFY, THAT I,	PRINT NAME OF PARENT OR GUAR	AM THE LEGAL PAR	ENT/GUARDIAN OF:
`			CDADE
	NAME OF CHILD	AGE	GRADE
THE FOLLOWING:	LD/CHILDREN AND I ARE LEGALLY		DGEFIELD PARK AT
CONTACT NUMBER:			_
PARK HAVE BEEN SUBMITTED FO OWNER OF DWELLING:			OF RIDGEFIELD
 Deed, Property Tax Record, Current Utility Bill RENTER OF DWELLING:	or Mortgage Statement reflecting the	Ridgefield Park address.	
Current original lease verifyir and phone number. If you do	ng names, status, and duration of leas o not have your current lease available cy. The affidavit must have the landlo	e you can complete the Landlor	d Affidavit of Residency.
3. Current Utility Bill			
PLEASI	E NOTE ADDITIONAL DOCUMENTA	TION MAY BE REQUIRED	
I	, affirm that I am the parent/guardian of the	e student(s) listed on this form. I further	state that this form and
the attached documents constitute true and	accurate proof that the student(s) listed on this		
, ,	student listed on this form stops living with me the Ridgefield Park Board of Education in writing	•	ty of Ridgefield Park
	d on this form is not my valid residence, I a		to nay the fuition rate:
	to the Ridgefield Park Board of Education fo	· · · · · · · · · · · · · · · · · · ·	
I certify that the following statements managed subject to punishment under the law.	ade by me are true, I am aware that if any of	the foregoing statements made by m	e are false, I am
NAME (PRINTED)	SIGNATURE	DATE	

LANDLORD AFFIDAVIT OF RESIDENCY

DATE:		
STATE OF NEW JERSEY COUNTY OF BERGEN		
I, of full age, bei	ing duly sworn upon his or her oath, according to the la	w, depose and
say:		
I am the owner of property located at	in the City	of Ridgefield Park.
2 is a tenant and h	as been a tenant at the above premises since	(month
(year).		
3. The names of permissible tenants are as follow	s:	
LIST ALL THE NAMES OF THE ADULTS AND C	HILDREN AUTHORIZED TO LIVE AT THE ABOVE SA	<u>ID ADDRESS</u>
1.	5.	
2.	6.	
3.	7.	
4.	8.	
	-	-
I am making this affidavit knowing that the Board of Edu	ication of the Village of Ridgefield Park will rely on the	same in determinir
whether	will be considered a pupil who is entitled to an education	on free of charge.
(NAME OF STUDENT)		_
	LANDLORD'S NAME:	
	LANDLORD'S ADDRESS:	
	 LANDLORD'S CONTACT #:	
	LANDLORD'S SIGNATURE:	
SWORN AND SUBSCRIBED BEFORE ME		
THIS DAY OF		
YEAR		
NOTARY PUBLIC		

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ACADEMIC RECORDS REQUEST FORM

Roosevelt School

RPJRSRHS

Office of Special Services

Grant School

Lincoln School

104 Henry Street 201-641-0441	712 Lincoln Avenue 201-994-1830	508 Teaneck Road 201-440-0808	One Ozzie Nelson Drive 201-440-1440	98 Central Avenue 201-807-2650
Date:				
The child named belo	w has enrolled in one	of our schools. The p	arent/guardian has au	thorized that the
following records show	uld be sent to the scho	ool circled above as so	oon as possible:	
☐ Academic (incl	uding report card, trar	nscript, standardized to	est scores, I.E.P.)	
☐ Attendance				
□ Disciplinary				
☐ Medical/Health				
☐ Confidential				
Full name of previous	school:			
Street Address:				
City/State/Zip:				
Telephone No.:				
Fax No.:				
Contact Email:				
Thank You for your o	cooperation.			
I hereby give permiss confidential school red			alth, disciplinary, and a	any
Child's Name:				
Current Grade Level:				
Parent/Guardian Nam	ne (Print):			
Parent/Guardian Sign	ature:			

SPECIAL EDUCATION MEDICAID INITIATIVE (SEMI)

RIDGEFIELD PARK SCHOOL DISTRICT:

Our school district is participating in the Special Education Medicaid Initiative (SEMI) program that allows school districts to bill Medicaid for services that are provided to students.

In accordance with the Family Educational Rights and Privacy Act, 34 CFR §99.30 and Section 617 of the IDEA Part B, consent requirements in 34 CFR §300.622 require a one-time consent before accessing public Benefits.

This consent establishes that your child's personally identifiable information, such as student records or information about services provided to your child, including evaluations and services as specified in my child's Individualized Education Program (IEP) (occupational therapy, physical therapy, speech therapy, psychological counseling, audiology, nursing and specialized transportation,) may be disclosed to Medicaid and the Department of the Treasury for the purpose of receiving Medicaid reimbursement at the school District.

As parent/guardian of the child named below, I give permission to disclose information as described above and I understand and agree that Medicaid may access my child's or my public benefits or public insurance to pay for special education or related services under Part 300 (services under the IDEA). I understand that the school district is still required to provide services to my child pursuant to his or her IEP, regardless of my Medicaid eligibility status or willingness to consent for SEMI billing

I understand that billing for these services by the district does not impact my ability to access these services for my child outside of the school setting, nor will any cost be incurred by my family including co-pays, deductibles, loss of eligibility or impact on lifetime benefits.

Child's Name:			
Date of Birth:			
Parent/Guardian Signature:			
Date:			
I give consent to bill for SEMI:			
☐ YES			
□ NO			

This consent can be revoked at any time by contacting your child's Case Manager, or the administrator at your child's school, in writing.

Home Language Survey

Purpose: The home language survey is used solely to offer appropriate educational services (U.S. ED EL Toolkit, Chapter 1). This survey is the first of three steps to identify whether or not a student is eligible to be identified as an English language learner (ELL). "Home" is defined as a student's current place of Residence.

Student Information:
Student Name:
Date of Birth (YYYYMMDD):
Current Address:
Survey Questions:
1.) List all languages used in the student's home.
2.) Was the first language used by the student a language other than English? NoYes
3.) Does the student speak or understand a language other than English?
NoYes
4.) When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English most of the time? NoYes
5.) When interacting with others outside the home (example: friends, caregivers), does the student understand or use a language other than English most of the time? NoYes

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DATE:		

MEDICAL HISTORY FORM

LAST				FIRST		MIDDLE
DATE OF BIRTH:/	/			AGE:		
	<u>P</u>	lease co	omplete the chil	d's health	history below.	
DIAGNOSIS	YES	<u>NO</u>	DATE OF DIAC	SNOSIS	TREATMENT AN	ID/OR RESTRICTIONS
ASTHMA						
BLOOD DISORDER						
CHICKEN POX						
DIABETES						
HEAD INJURY						
HEART PROBLEM						
SEIZURE						
SKIN CONDITION						
SPEECH/LANGUAGE						
URINARY PROBLEM						
VISION/GLASSES						
Current Medicational Places i	naluda th		of the modicine	the decea	time and reason for a	100
Current Medications: Please i NAME OF MEDICINE	riciude tri		SAGE	ine dosage	TIME	REASON
	ļ					
lospitalizations for illness or	surgery	: Please	include diagnos	s and year	r.	
HOSPITALIZATION REASON			DIAG	<u>IOSIS</u>		<u>YEAR</u>
GIVE MY PERMISSION FO	R THIS	INFOR	MATION TO B	E SHARE	D WITH APPROPRI	ATE SCHOOL STAFF.
PARENT/GUARDIAN NAME	i:					
PARENT/GUARDIAN NAME	i:					
I GIVE MY PERMISSION FO PARENT/GUARDIAN NAME PARENT/GUARDIAN SIGNA RELATIONSHIP TO CHILD:	E:					

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ALLERGY RECORD FORM						
CHILD'S NAME:						
LAST	ſ			FIRST	MIDDLE	
DATE OF BIRTH:	/	/_	AG	E:		
If your child h	nas <u>N</u>	Ю а	llergies/reactions p	lease check here	and sign below.	
<u>ITEM</u>	<u>YES</u>	<u>NO</u>	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						
OTHER FOOD:			ADDITIONAL INF	ORMATION		
FOOD			TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN	
1000			THE OF REACTION	MEDIOATION TAKEN	ACTIONO TO BE TAKEN	
OTHER ANIMALS:						
ANIMAL			TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN	
OTHER MEDICATION	DN:					
MEDICATION			TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN	
OTHER ALLERGIES	<u>S:</u>					
<u>ALLERGIES</u>			TYPE OF REACTION	MEDICATION TAKEN	ACTIONS TO BE TAKEN	
PARENT/GUARDIA	N SIG	NATU	IRE:		DATE:	

RELATIONSHIP TO CHILD:

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DATE:	

MEDICATION FORM

CHILD'S NAM	ЛЕ:						
	LAST			FIR	ST		MIDDLE
DATE OF BIR	RTH:/	/		AGE:			
PARENT/GUA	ARDIAN NAME:						-
RELATIONSH	HIP TO CHILD: _					· · · · · · · · · · · · · · · · · · ·	
products must	-	e school nurse b	y a parent/g		onnot one single d ctions for use from a	•	1
By my signatu the school day	<u>-</u>	ny child does no	t need to take	e any prescribed	or over-the-counter	medication during)
PARENT/GUA	ARDIAN SIGNAT	URE:					
DATE:							
Permission maconditions if the may require the By my signature that Ridgefield by my child ar	ne school received nat the medication are below I give pe d Park Public Sch	your child for sets written permiss to be self-administermission for my cools shall incurity and hold harn	sion from a p stered in the child to self- no liability as nless the Rid	arent/guardian a presence of the administer the n a result of any ing gefield Park Boa	nedication indicated njury arising from the rd of Education and	a physician. Even by the physician. I e self-administration	in this case, we understand on of medication
PARENT/GUA	ARDIAN SIGNAT	URE:			DATE: _		
RELATIONSH	HIP TO CHILD: _				_		
TO BE COMP	LETED BY PHY	SICIAN'S OFFIC	CE:				
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
Physician's S Physician's N SIGNATURE:	re mentioned chi elf-administering <u>Signature and St</u> Name:	the medication	n noted abo	ve.	g condition and ha	s been instructed	d in and is
_							
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

Name			Date of birth		
Sex Age Grade Sch	ool		Sport(s)		
Medicines and Allergies: Please list all of the prescription and over	-the-co	unter m	edicines and supplements (herbal and nutritional) that you are currently	taking	
3					
Do you have any allergies? ☐ Yes ☐ No ☐ If yes, please iden ☐ Medicines ☐ Pollens	ntify spe	ecific all	ergy below. ☐ Food ☐ Stinging Insects		
			1 Junying insects		
Explain "Yes" answers below. Circle questions you don't know the an	swers t	0.	[l	
GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS 26 De vou cough wheeve or hous difficulty breething during or	Yes	No
 Has a doctor ever denied or restricted your participation in sports for any reason? 			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
Do you have any ongoing medical conditions? If so, please identify			27. Have you ever used an inhaler or taken asthma medicine?		
below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections			28. Is there anyone in your family who has asthma?		<u> </u>
Other:			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
Have you ever had surgery?			30. Do you have groin pain or a painful bulge or hernia in the groin area?		+
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	31. Have you had infectious mononucleosis (mono) within the last month?		1
5. Have you ever passed out or nearly passed out DURING or			32. Do you have any rashes, pressure sores, or other skin problems?		
AFTER exercise?			33. Have you had a herpes or MRSA skin infection?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			34. Have you ever had a head injury or concussion?		<u> </u>
7. Does your heart ever race or skip beats (irregular beats) during exercise?			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
8. Has a doctor ever told you that you have any heart problems? If so,			36. Do you have a history of seizure disorder?		+
check all that apply: ☐ High blood pressure ☐ A heart murmur			37. Do you have headaches with exercise?		
☐ High cholesterol ☐ A heart infection			38. Have you ever had numbness, tingling, or weakness in your arms or		
☐ Kawasaki disease Other:			legs after being hit or falling?		₩
Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			39. Have you ever been unable to move your arms or legs after being hit or falling?		$oxed{oxed}$
10. Do you get lightheaded or feel more short of breath than expected			40. Have you ever become ill while exercising in the heat?		₩
during exercise? 11. Have you ever had an unexplained seizure?			41. Do you get frequent muscle cramps when exercising?		┼
Do you get more tired or short of breath more quickly than your friends			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?		\vdash
during exercise?			44. Have you had any eye injuries?		+
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	45. Do you wear glasses or contact lenses?		1
 Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including 			46. Do you wear protective eyewear, such as goggles or a face shield?		
drowning, unexplained car accident, or sudden infant death syndrome)?			47. Do you worry about your weight?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan			48. Are you trying to or has anyone recommended that you gain or		
syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			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?		+
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			51. Do you have any concerns that you would like to discuss with a doctor?		T
Has anyone in your family had unexplained fainting, unexplained			FEMALES ONLY		
seizures, or near drowning?			52. Have you ever had a menstrual period?		
BONE AND JOINT QUESTIONS	Yes	No	53. How old were you when you had your first menstrual period?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			54. How many periods have you had in the last 12 months?		
Have you ever had any broken or fractured bones or dislocated joints?			Explain "yes" answers here		
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)					
Do you regularly use a brace, orthotics, or other assistive device? Do you have a bone, muscle, or joint injury that bothers you?					
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?					

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HE0503

9-2681/0410

■ PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Ex	am					
Name				Date of bir	th	
	Ago	Grade	School			
Sex	Age	Grade	Scilooi	Sport(s)		
1. Type o	of disability					
2. Date o	of disability					
3. Classit	ification (if available)					
4. Cause	of disability (birth, d	lisease, accident/trauma, other)				
5. List th	ne sports you are inte	rested in playing				
					Yes	No
6. Do you	u regularly use a bra	ce, assistive device, or prosthet	ic?			
		ace or assistive device for sports				
		ressure sores, or any other skin	problems?			
		s? Do you use a hearing aid?				
	u have a visual impa					
		vices for bowel or bladder funct	ion?			
		scomfort when urinating?				
_	you had autonomic d					
			hermia) or cold-related (hypothermia) illne	SS?		
	u have muscle spasti		u madication?			
		ures that cannot be controlled b	y medication?			
Explain "ye	es" answers here					
Please indi	icate if you have ev	er had any of the following.				
					Yes	No
Atlantoaxia	al instability					
1						
X-ray evalu	uation for atlantoaxia	al instability				
	uation for atlantoaxia I joints (more than on					
	l joints (more than on					
Dislocated	l joints (more than on ding					
Dislocated Easy bleed	l joints (more than on ding					
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia	d joints (more than on ding spleen a or osteoporosis					
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia	d joints (more than on ding spleen a or osteoporosis controlling bowel					
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c	d joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder	16)				
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c Numbness	d joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder s or tingling in arms of	or hands				
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c Numbness Numbness	d joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder s or tingling in arms of s or tingling in legs or	or hands				
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c Difficulty c Numbness Numbness Weakness	d joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder s or tingling in arms of s or tingling in legs or in arms or hands	or hands				
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c Difficulty c Numbness Numbness Weakness Weakness	d joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder s or tingling in arms of s or tingling in legs or s in arms or hands in legs or feet	or hands				
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c Difficulty c Numbness Numbness Weakness Weakness Recent cha	I joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder s or tingling in arms of s or tingling in legs or in arms or hands in legs or feet ange in coordination	or hands				
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c Difficulty c Numbness Weakness Weakness Recent cha	I joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder s or tingling in arms of s or tingling in legs or in arms or hands in legs or feet ange in coordination ange in ability to wal	or hands				
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c Difficulty c Numbness Weakness Weakness Recent cha	I joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder s or tingling in arms of s or tingling in legs or in arms or hands in legs or feet ange in coordination ange in ability to wal	or hands				
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c Difficulty c Numbness Weakness Weakness Recent cha	I joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder s or tingling in arms of s or tingling in legs or in arms or hands in legs or feet ange in coordination ange in ability to wal	or hands				
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c Numbness Numbness Weakness Recent cha Recent cha Recent cha Latex aller	I joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder s or tingling in arms of s or tingling in legs or in arms or hands in legs or feet ange in coordination ange in ability to wal	or hands				
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c Numbness Numbness Weakness Recent cha Recent cha Recent cha Latex aller	I joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder s or tingling in arms or s or tingling in legs or i in arms or hands i in legs or feet ange in coordination ange in ability to wal	or hands				
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c Numbness Numbness Weakness Recent cha Recent cha Recent cha Latex aller	I joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder s or tingling in arms or s or tingling in legs or i in arms or hands i in legs or feet ange in coordination ange in ability to wal	or hands				
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c Numbness Numbness Weakness Recent cha Recent cha Recent cha Latex aller	I joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder s or tingling in arms or s or tingling in legs or i in arms or hands i in legs or feet ange in coordination ange in ability to wal	or hands				
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c Numbness Numbness Weakness Recent cha Recent cha Recent cha Latex aller	I joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder s or tingling in arms or s or tingling in legs or i in arms or hands i in legs or feet ange in coordination ange in ability to wal	or hands				
Dislocated Easy bleed Enlarged s Hepatitis Osteopenia Difficulty c Numbness Numbness Weakness Recent cha Recent cha Recent cha Latex aller	I joints (more than or ding spleen a or osteoporosis controlling bowel controlling bladder s or tingling in arms or s or tingling in legs or i in arms or hands i in legs or feet ange in coordination ange in ability to wal	or hands				
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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 • Do you wear a seat belt, use a helmet, and use condoms?	performance?	Date of Shari
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).		
EXAMINATION Height Weight □ Male	☐ Female	
		L 20/ Corrected Y N
BP / (/) Pulse Vision	NORMAL	L 20/ Corrected Y N ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) Eyes/ears/nose/throat	NUKMAL	ABNUKMAL FINDINGS
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		
"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 treatments.	ent 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 evparticipate in the sport(s) as outlined above. A copy of the physical exam is on record in my arise after the athlete has been cleared for participation, a physician may rescind the clearate to the athlete (and parents/guardians). Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)	office and can be mance until the problem	ade available to the school at the request of the parents. If conditions is resolved and the potential consequences are completely explained
Address		Phone

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HEGEGIS

Signature of physician, APN, PA _

■ PREPARTICIPATION PHYSICAL EVALUATION

CLEARANCE FORM

Name	Sex 🗆 M 🗆 F Age Date of birth
☐ Cleared for all sports without restriction	
$\hfill\Box$ Cleared for all sports without restriction with recommendations for further evaluations for further evaluations are consistent as the contract of t	aluation 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:
I OTTIGE STAIN	
	Reviewed on(Date)
	Approved Not Approved
	Signature:
	articipation physical evaluation. The athlete does not present apparent 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 paren	nts. If conditions arise after the athlete has been cleared for participation,
the physician may rescind the clearance until the problem is resolv (and parents/guardians).	ed and the potential consequences are completely explained to the athle
Name of physician, advanced practice nurse (APN), physician assistant (PA)) Date
	Phone
Signature of physician, APN, PA	
Completed Cardiac Assessment Professional Development Module	
DateSignature	

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