ALL HIGH SCHOOL ATHLETES
ALL INTERMEDIATE SCHOOL ATHLETES

A. We encourage Parents/Guardians to bring athletes to your family physician since your own physician knows the medical history of your child (physical is at Parents/Guardians expense). Physicals done privately must still be signed off by the school doctor (N.J.A.C.6A:16-2.2). This process takes 2 weeks, so keep this in mind if you wish to make the deadline for Sports try-outs. No student shall try-out or participate in a sport or intramurals until the school doctor has reviewed and signed off on the physical. It is important that you follow directions on the following page when you go to your own physician.

B. There will be NO physicals offered this school year.
TOMS RIVER SCHOOL SPORTS PHYSICAL PROCEDURES

All students trying out for any interscholastic sports must have a sports physical. Sports Physicals are good for one calendar year (365 Days) so we encourage students to have a physical during the months of June and July. **Athletes will then be covered for fall, winter and spring sports.**

A. When having your Family Physician or Advanced Practice Nurse (APN) perform your physical, please adhere to the following:

1. Complete Health History Questionnaire.
2. Bring Health History Questionnaire and Pre-participation Physical Exam Form to your physician for completion with three-part NCR approval form. **Please make sure every item is complete i.e. vision, hernia and doctor’s signature with his stamp as well as the completion of the Student-Athlete Cardiac Assessment Professional Development Module.**
3. Bring all completed forms to the school nurse or the main office in your school as soon as possible. The physical is then reviewed by our school physician for approval. **This procedure takes 2 weeks, so keep this in mind if you wish to make the deadline for Sports try-outs.**
4. If you carry an Epipen, please pick up an Epipen packet at the nurse’s office to be completed by parent and the physician.
5. If you carry an inhaler, the attached Asthma Action Plan must be completed by your physician and signed by both physician and parent.
6. If you wear eyeglasses, bring them to your physical.
7. If a student has diabetes, the parent and physician must complete the Diabetes Care Plan packet that can be picked up at the nurse’s office.
8. **FAMILY PHYSICIAN’S NOTE WILL NOT BE ACCEPTED AS A REQUIREMENT FOR A SPORT’S PHYSICAL**

**High School – Academic Eligibility**

**Fall Sports:** Sophomores, Juniors and Seniors must pass 30 credits previous school year including summer school. All freshman are eligible.

**Winter Sports:** Sophomores, Juniors and Seniors must pass 30 credits previous school year including summer school. All Freshman are eligible.

**Spring Sports:** Freshman, Sophomores, Juniors and Seniors must be passing 30 credits, Seniors must be passing all courses in which they have enrolled.

**Intermediate – Academic Eligibility**

**Board Policy 6145 – Good Academic Standing**

Intermediate students will be ineligible to participate in Sports if they have received one “F” or two “D’s” in any subject during the quarter preceding the start of the season.
SPORTS PROGRAM AT THE INTERMEDIATE LEVEL GRADES SIX, SEVEN AND EIGHT
Numerous sports are offered at the Intermediate level

Fall Sports Include: Girls’ Soccer, Boys’ Soccer, Field Hockey, Girls’ Cross Country, Boys’ Cross Country, Cheerleading, Girls’ Volleyball
Winter Sports Include: Girls’ Basketball, Boys Basketball, Wrestling, Cheerleading
Spring Sports Include: Softball, Baseball, Girls’ Track, and Boys’ Track

ALL INTRAMURALS SPORTS PHYSICALS REQUIRED
In order to try out and participate in the Interscholastic Athletic Program every student must have an approved Sports Physical. This physical is good for 1 year from the date of the physical.

All physicals obtained by a private Physician must be written on the Toms River Schools Sports Packet. The completed packet should be turned into the Nurses Office at least 2 weeks prior to the sports try-outs. Physicals done privately must still be signed off by the school Doctor (N.J.A.C.6A:16-2.2). This process takes 2 weeks, so keep this in mind if you wish to make the deadline for Sports try-outs. No student shall try-out or participates in a sport or intramurals until the School Doctor has reviewed and signed off on it.

Questions about Sports Physicals please call: IE-732-505-5780; IN-732-505-5805; IS-732-505-3916

Good Academic Standing: All students desiring to participate in interschool athletic competition must meet the following eligibility requirements:

Fall Sports: Students must meet promotion requirements from the previous grade to be eligible. Students retained will be ineligible for the fall semester sports. Student athletes are expected to maintain eligibility during the season. Progress reports will be utilized to determine a possible probationary period from the team.

Winter Sports: The first marking period report card will be used to determine eligibility to participate. Student athletes are expected to maintain eligibility during the season. Progress reports will be utilized to determine a possible probationary period from the team.

Spring Sports: The second school report card will be used to determine eligibility to participate. Student athletes are expected to maintain eligibility during the season. Third marking period report cards and progress reports will be utilized to determine a possible probationary period from the team.

Academic Eligibility - Students will be ineligible for sports if they have received an "F" or two (2) "D's" in any core subject (Mathematics, Social Studies, Language Arts, Science). In addition, students must maintain a "C" average (2.5) or better in their activity classes.

* Any "F" received in either a core subject or an activity class will make a student ineligible to participate.

Progress Reports - progress reports which indicate "In Danger of Failing" will be investigated to determine if a probationary period is warranted.

Probationary period from the team - If the student athlete is determined ineligible during the season; he/she may serve a probationary period from any game, match or meet. If the overall grade point average (GPA) is improved to a "C" during the probationary period, the student athletes are again eligible to compete in games. Student athletes will remain ineligible and the probationary process will continue if the overall GPA remains below a "C". Student athletes will be expected to practice with their team during this probationary period.
Prior to participation on a school-sponsored interscholastic or intramural athletic team or squad, each student-athlete in grades six through 12 must present a completed pre-participation physical evaluation (PPE) form to the designated school staff member. Important information regarding the PPE is provided below, and you should feel free to share with your child’s medical home health care provider.

1. **The PPE may ONLY be completed by a licensed physician, advanced practice nurse (APN) or physician assistant (PA) that has completed the Student-Athlete Cardiac Assessment professional development module.** It is recommended that you verify that your medical provider has completed this module before scheduling an appointment for a PPE.

2. The required PPE must be conducted within 365 days prior to the first official practice in an athletic season. The PPE form is available in English and Spanish at [http://www.state.nj.us/education/students/safety/health/records/athleticphysicalsform.pdf](http://www.state.nj.us/education/students/safety/health/records/athleticphysicalsform.pdf).

3. The parent/guardian must complete the *History Form* (page one), and insert the date of the required physical examination at the top of the page.

4. The parent/guardian must complete *The Athlete with Special Needs: Supplemental History Form* (page two), if applicable, for a student with a disability that limits major life activities, and insert the date of the required physical examination on the top of the page.

5. The licensed physician, APN or PA who performs the physical examination must complete the remaining two pages of the PPE, and insert the date of the examination on the *Physical Examination Form* (page three) and *Clearance Form* (page four).

6. The school district must provide written notification to the parent/guardian, signed by the school physician, indicating approval of the student’s participation in a school-sponsored interscholastic or intramural athletic team or squad based upon review of the medical report, or must provide the reason(s) for the disapproval of the student’s participation.

7. For student-athletes that had a medical examination completed more than 90 days prior to the first official practice in an athletic season, the *Health History Update Questionnaire* (HHQ) form must be completed, and signed by the student’s parent/guardian. The HHQ must be reviewed by the school nurse and, if applicable, the school’s athletic trainer. The HHQ is available at [http://www.state.nj.us/education/students/safety/health/records/HealthHistoryUpdate.pdf](http://www.state.nj.us/education/students/safety/health/records/HealthHistoryUpdate.pdf).

For more information, please review the *Frequently Asked Questions* which are available at [http://www.state.nj.us/education/students/safety/health/services/athlete/faq.pdf](http://www.state.nj.us/education/students/safety/health/services/athlete/faq.pdf). You may also direct questions to Toms River Regional Schools.
**TOMS RIVER REGIONAL SCHOOLS**  
**PREPARTICIPATION PHYSICAL EVALUATION**  

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

<table>
<thead>
<tr>
<th>Name: _____________________________________________</th>
<th>School: ____________________________________________</th>
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</thead>
<tbody>
<tr>
<td>Age:______<em><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong>Grade</strong></strong></strong></strong></strong></strong></strong></strong></strong></strong></strong></em></td>
<td>Sport_______________________________________</td>
</tr>
<tr>
<td>Parent's Name_______________________________________</td>
<td>Address: ___________________________________________</td>
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<tr>
<td>Phone #'s: (H)<em><strong><em><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong>(C)</strong></strong></strong></strong></strong></strong></strong></strong></strong></strong></strong></strong></strong></em>(W)</strong></em>___________________________</td>
<td></td>
</tr>
<tr>
<td>Examining Physician Name: ____________________________</td>
<td>Address: ___________________________________________</td>
</tr>
<tr>
<td>Phone: ________________________________________________</td>
<td>Fax: ____________________________________________</td>
</tr>
</tbody>
</table>

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

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

Explain “Yes” answers on following page. Circle questions you don’t know the answers to.

**GENERAL QUESTIONS**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever denied or restricted your participation in sports for any reason?</td>
<td></td>
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<tr>
<td>2. Do you have any ongoing medical conditions? If so, please identify below:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>Anemia</td>
<td>Diabetes</td>
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<tr>
<td>Other:</td>
<td></td>
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<tr>
<td>3. Have you ever spent the night in the hospital?</td>
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<tr>
<td>4. Have you ever had surgery?</td>
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</tbody>
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**HEART HEALTH QUESTIONS ABOUT YOU**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>5. Have you ever passed out or nearly passed out DURING or AFTER exercise?</td>
<td></td>
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<tr>
<td>6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
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<tr>
<td>7. Does your heart ever race or skip beats (irregular beats) during exercise?</td>
<td></td>
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<tr>
<td>8. Has a doctor ever told you that you have any heart problems? If so, check all that apply:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td>A heart murmur</td>
<td>High cholesterol</td>
</tr>
<tr>
<td>A heart infection</td>
<td>Kawasaki disease</td>
<td>Other:</td>
</tr>
<tr>
<td>9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you get lightheaded or feel more short of breath than expected during exercise?</td>
<td></td>
<td></td>
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<tr>
<td>11. Have you ever had an unexplained seizure?</td>
<td></td>
<td></td>
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<tr>
<td>12. Do you get more tired or short of breath more quickly than your friends during exercise?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HEART HEALTH QUESTIONS ABOUT YOUR FAMILY**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)?</td>
<td></td>
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</tr>
<tr>
<td>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?</td>
<td></td>
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</tr>
<tr>
<td>15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?</td>
<td></td>
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<tr>
<td>16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?</td>
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</tbody>
</table>

**BONE AND JOINT QUESTIONS**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or game?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Have you ever had any broken or fractured bones or dislocated joints?</td>
<td></td>
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<tr>
<td>19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</td>
<td></td>
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<tr>
<td>20. Have you ever had a stress fracture?</td>
<td></td>
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<tr>
<td>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)</td>
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<tr>
<td><strong>BONE AND JOINT QUESTIONS (CONT.)</strong></td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>22. Do you regularly use a brace, orthotics, or other assistive device?</td>
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<tr>
<td>23. Do you have a bone, muscle, or joint injury that bothers you?</td>
<td></td>
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<tr>
<td>24. Do any of your joints become painful, swollen, feel warm, or look red?</td>
<td></td>
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<tr>
<td>25. Do you have any history of juvenile arthritis or connective tissue disease?</td>
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</tbody>
</table>

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

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

TOMS RIVER REGIONAL SCHOOLS
PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name:________________________________________Date of Birth:____________Grade:________Sport:_____________

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

<table>
<thead>
<tr>
<th>Height:</th>
<th>Weight:</th>
<th>☐ Male</th>
<th>☐ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP:</td>
<td>(</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse:</td>
<td>Vision:</td>
<td>R 20/</td>
<td>L20/</td>
</tr>
</tbody>
</table>

MEDICAL

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Marfan Stigmata</td>
<td></td>
<td>(kyphoscoliosis,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>high-arched palate,</td>
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<tr>
<td></td>
<td></td>
<td>pectus excavatum,</td>
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<tr>
<td></td>
<td></td>
<td>arachnodactyly, arm</td>
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<tr>
<td></td>
<td></td>
<td>span/height, hyperf</td>
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<td></td>
<td></td>
<td>laxity, myopia, MVP,</td>
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<td></td>
<td></td>
<td>aortic insufficiency)</td>
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</table>

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
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</thead>
<tbody>
<tr>
<td>Eyes/ears/nose/throat</td>
<td></td>
<td></td>
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<tr>
<td>• Pupils equal</td>
<td></td>
<td></td>
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<tr>
<td>• Hearing</td>
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<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
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</thead>
<tbody>
<tr>
<td>Lymph nodes</td>
<td></td>
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<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
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<tbody>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Murmurs (auscultation standing, supine, +/- Valsalva</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Location of point of maximal impulse (PMI)</td>
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<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
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<tbody>
<tr>
<td>Pulses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Simultaneous femoral and radial pulses</td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
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</thead>
<tbody>
<tr>
<td>Lungs</td>
<td></td>
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<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
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</thead>
<tbody>
<tr>
<td>Abdomen</td>
<td></td>
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<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
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</thead>
<tbody>
<tr>
<td>Genitourinary (males only)</td>
<td></td>
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<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• HSV, lesions suggestive of MRSA, tinea corporis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurologic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

|MUSCULOSKELETAL    |        |                   |

| MUSCULOSKELETAL   |        |                   |
| Neck              |        |                   |

| MUSCULOSKELETAL   |        |                   |
| Back/Scoliosis check |      |                   |

| MUSCULOSKELETAL   |        |                   |
| Shoulder/arm      |        |                   |

| MUSCULOSKELETAL   |        |                   |
| Elbow/forearm     |        |                   |

| MUSCULOSKELETAL   |        |                   |
| Wrist/hand/fingers|        |                   |

| MUSCULOSKELETAL   |        |                   |
| Hip/thigh         |        |                   |

| MUSCULOSKELETAL   |        |                   |
| Knee              |        |                   |

| MUSCULOSKELETAL   |        |                   |
| Leg/ankle         |        |                   |

| MUSCULOSKELETAL   |        |                   |
| Foot/toes         |        |                   |

| MUSCULOSKELETAL   |        |                   |
| 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.
PHYSICAL EXAMINATION FORM (pg 2)
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 ☐ Needs epi-pen
____________________________________________________________________________________________________
____________________________________________________________________________________________________

Medications / Recent Immunizations and date administered
____________________________________________________________________________________________________
____________________________________________________________________________________________________

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 outlines 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).

Provider License type:
☐ MD/DO
☐ APN (Advanced Practice Nurse)
☐ PA (Physician Assistant)

HCP OFFICE STAMP:

SCHOOL PHYSICIAN:

Reviewed on __________________________ (Date)
Approved__________ Not Approved__________
Signature:____________________________________________ (Date)

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____________________________ Date of Exam ____________

Address __________________________________________ Phone __________________

Signature of physician, APN, PA ________________________________________________________________

Completed Cardiac Assessment Professional Development Module

Name __________________________________________ Date ____________

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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Do you regularly use a brace, assistive device, or prosthetic?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Do you use any special brace or assistive device for sports?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Do you have any rashes, pressure sores, or any other skin problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you have a visual impairment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Do you use any special devices for bowel or bladder function?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Have you had autonomic dysreflexia?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Do you have muscle spasticity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explain “yes” answers here

________________________________________________________

________________________________________________________

Please indicate if you have ever had any of the following.

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

Explain “yes” answers here

________________________________________________________

________________________________________________________

________________________________________________________

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 _____________________

ADDENDUM

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
- One-eyed athletes or athletes with vision greater than 20/40 in one eye.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

<table>
<thead>
<tr>
<th>Contact/Collision</th>
<th>Limited Contact</th>
<th>Non-Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basketball</td>
<td>Baseball</td>
<td>Discus</td>
</tr>
<tr>
<td>Diving</td>
<td>Cheerleading</td>
<td>Bowling</td>
</tr>
<tr>
<td>Field Hockey</td>
<td>Fencing</td>
<td>Javelin</td>
</tr>
<tr>
<td>Football</td>
<td>High Jump</td>
<td>Shot put</td>
</tr>
<tr>
<td>Ice Hockey</td>
<td>Pole vault</td>
<td>Rowing</td>
</tr>
<tr>
<td>Lacrosse</td>
<td>Gymnastics</td>
<td>Running/Cross Country</td>
</tr>
<tr>
<td>Soccer</td>
<td>Skiing</td>
<td>Strength Training</td>
</tr>
<tr>
<td>Wrestling</td>
<td>Softball</td>
<td>Swimming</td>
</tr>
<tr>
<td></td>
<td>Volleyball</td>
<td>Tennis</td>
</tr>
</tbody>
</table>

Effects of physiologic maneuvers on heart sounds

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

**Squating**
- 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 Regurgitation
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

NJDOE/APPEF Revised 3/10 Use of this form is required by N.J.A.C. 6A:16-Programs to Support Student Development
Toms River Regional Schools

Sudden Cardiac Death Pamphlet
Sign-Off Sheet

I/We acknowledge that we received the Sudden Cardiac Death in Young Athletes pamphlet.

Student Signature ______________________________________________________

Print Athletes Name _____________________________________________________

Parent/Guardian Signature _______________________________________________

Print Parent/Guardian Name ______________________________________________

Date __________________________________

New Jersey Department of Education 2014: pursuant to the Scholastic Student-Athlete Safety Act, P.L. 2013, c.71
SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

The Basic Facts on Sudden Cardiac Death in Young Athletes

Sudden death in young athletes between the ages of 10 and 19 is very rare. What, if anything, can be done to prevent this kind of tragedy?

What is sudden cardiac death in the young athlete?

Sudden cardiac death is the result of an unexpected failure of proper heart function, usually (about 60% of the time) during or immediately after exercise without trauma. Since the heart stops pumping adequately, the athlete quickly collapses, loses consciousness, and ultimately dies unless normal heart rhythm is restored using an automated external defibrillator (AED).

How common is sudden death in young athletes?

Sudden cardiac death in young athletes is very rare. About 100 such deaths are reported in the United States per year. The chance of sudden death occurring to any individual high school athlete is about one in 200,000 per year.

Sudden cardiac death is more common in males than in females; in football and basketball rather than in other sports; and in African-Americans than in other races and ethnic groups.

What are the most common causes?

Research suggests that the main cause is a loss of proper heart rhythm, causing the heart to quiver instead of pumping blood to the brain and body. This is called ventricular fibrillation (ven-TRICK-you-lar fib-ROO-lay-shun). The problem is usually caused by one of several cardiovascular abnormalities and electrical diseases of the heart that go unnoticed in healthy-appearing athletes.

The most common cause of sudden death in an athlete is hypertrophic cardiomyopathy (hi-per-TRICK-foe-ar CAR-me-o-pah-the) also called HCM. HCM is a disease of the heart, with abnormal thickening of the heart muscle, which can cause serious heart rhythm problems and blockages to blood flow. This genetic disease runs in families and usually develops gradually over many years.

The second most likely cause is congenital (con-JEN-it-al) (i.e., present from birth) abnormalities of the coronary arteries. This means that these blood vessels are connected to the main blood vessel of the heart in an abnormal way. This differs from blockages that may occur when people get older (commonly called “coronary artery disease,” which may lead to a heart attack).
SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

Other diseases of the heart that can lead to sudden death in young people include:
- Myocarditis (my-oh-cat-DIE-tis), an acute inflammation of the heart muscle (usually due to a virus).
- Dilated cardiomyopathy, an enlargement of the heart for unknown reasons.
- Long QT syndrome and other electrical abnormalities of the heart which cause abnormal fast heart rhythms that can also run in families.
- Marfan syndrome, an inherited disorder that affects heart valves, walls of major arteries, eyes and the skeleton. It is generally seen in unusually tall athletes, especially if being tall is not common in other family members.

Are there warning signs to watch for?
In more than a third of these sudden cardiac deaths, there were warning signs that were not reported or taken seriously. Warning signs are:
- Fainting, a seizure or convulsions during physical activity;
- Fainting or a seizure from emotional excitement, emotional distress or being startled;
- Dizziness or lightheadedness, especially during exertion;
- Chest pains, at rest or during exertion;
- Palpitations - awareness of the heart beating unusually (skipping, irregular or extra beats) during athletics or during cool down periods after athletic participation;
- Fatigue or tiring more quickly than peers; or
- Being unable to keep up with friends due to shortness of breath (labored breathing).

What are the current recommendations for screening young athletes?
New Jersey requires all school athletes to be examined by their primary care physician (“medical home”) or school physician at least once per year. The New Jersey Department of Education requires use of the specific Preparticipation Physical Examination Form (PPE).
This process begins with the parents and student-athletes answering questions about symptoms during exercise (such as chest pain, dizziness, fainting, palpitations or shortness of breath); and questions about family health history.
The primary healthcare provider needs to know if any family member died suddenly during physical activity or during a seizure. They also need to know if anyone in the family under the age of 50 had an unexplained sudden death such as drowning or car accidents. This information must be provided annually for each exam because it is so essential to identify these at risk for sudden cardiac death.
The required physical exam includes measurement of blood pressure and a careful listening examination of the heart, especially for murmurs and rhythm abnormalities. If there are no warning signs reported on the health history and no abnormalities discovered on exam, no further evaluation or testing is recommended.

Are there options privately available to screen for cardiac conditions?
Technology-based screening programs including a 12-lead electrocardiogram (ECG) and echocardiogram (ECHO) are noninvasive and painless options parents may consider in addition to the required PPE. However, these procedures may be expensive and are not currently advised by the American Academy of Pediatrics and the American College of Cardiology unless the PPE reveals an indication for these tests.
In addition to the expense, other limitations of technology-based tests include the possibility of “false positives” which leads to unnecessary stress for the student and parent or guardian as well as unnecessary restriction from athletic participation.

When should a student athlete see a heart specialist?
If the primary healthcare provider or school physician physician has concerns, a referral to a child heart specialist, a pediatric cardiologist, is recommended. This specialist will perform a more thorough evaluation, including an electrocardiogram (ECG), which is a graph of the electrical activity of the heart. An echocardiogram, which is an ultrasound test to allow for direct visualization of the heart structure, will likely also be done. The specialist may also order a treadmill exercise test and a monitor to enable a longer recording of the heart rhythm. None of the testing is invasive or uncomfortable.

Can sudden cardiac death be prevented just through proper screening?
A proper evaluation should find most, but not all, conditions that would cause sudden death in the athlete. This is because some diseases are difficult to uncover and may only develop later in life. Others can develop following a normal screening evaluation, such as an infection of the heart muscle from a virus.
This is why screening evaluations and a review of the family health history need to be performed on a yearly basis by the athlete’s primary healthcare provider. With proper screening and evaluation, most cases can be identified and prevented.

Why have an AED on site during sporting events?
The only effective treatment for ventricular fibrillation is immediate use of an automated external defibrillator (AED). An AED can restore the heart back into a normal rhythm. An AED is also life-saving for ventricular fibrillation caused by a blow to the chest over the heart (commotio cordis).
N.J.S.A. 18A:40-41a through c known as “Janet's Law” requires that at any school-sponsored athletic event or team practice in New Jersey public and nonpublic schools including any of grades K through 12, the following must be available:
- An AED in an unlocked location on school property within a reasonable proximity to the athletic field or gymnasium; and
- A team coach, licensed athletic trainer, or other designated staff member if there is no coach or licensed athletic trainer present, certified in cardiopulmonary resuscitation (CPR) and the use of the AED; or
- A State-certified emergency services provider or other certified first responder.
The American Academy of Pediatrics recommends the AED should be placed in central location that is accessible and ideally no more than a 1 to 1 1/2 minute walk from any location and that a call is made to activate 911 emergency system while the AED is being retrieved.
TOMS RIVER REGIONAL SCHOOLS
INFORMED CONSENT FOR
ATHLETIC PARTICIPANTS

I GRANT PERMISSION TO THE MEDICAL STAFF OF TOMS RIVER REGIONAL
SCHOOLS TO RENDER CARE AND TREATMENT AS DEEMED NECESSARY AND
APPROPRIATE TO MY SON/DAUGHTER,
_________________________________________, SHOULD HE/SHE SUSTAIN

(PRINT NAME)

AN INJURY/ILLNESS RELATED TO PARTICIPATION IN A TOMS RIVER REGIONAL
SCHOOL SPONSORED ATHLETIC PRACTICE OR EVENT. FURTHER, I GIVE
PERMISSION TO THE TOMS RIVER REGIONAL SCHOOLS MEDICAL STAFF TO
CONSULT WITH OUR FAMILY HEALTHCARE PROVIDER SO THEY MAY PROVIDE
CONTINUED APPROPRIATE CARE AND TREATMENT TO RESTORE THE HEALTH
AND WELL BEING OF MY SON/DAUGHTER.

SIGNED:_______________________________DATE:________________

(Parent/Guardian)

CONCUSSION POLICY ACKNOWLEDGEMENT FORM (Required)

Signature of Student-Athlete Print Student-Athlete’s Name Date

Signature of Parent/Guardian Print Parent/Guardian’s Name Date

Failure to sign will render your son/daughter ineligible for participation.
A concussion is a brain injury that can be caused by a blow to the head or body that disrupts normal functioning of the brain. Concussions are a type of Traumatic Brain Injury (TBI), which can range from mild to severe and can disrupt the way the brain normally functions. Concussions can cause significant and sustained neuropsychological impairment affecting problem solving, planning, memory, attention, concentration, and behavior.

The Centers for Disease Control and Prevention estimates that 300,000 concussions are sustained during sports related activities nationwide, and more than 62,000 concussions are sustained each year in high school contact sports. Second-impact syndrome occurs when a person sustains a second concussion while still experiencing symptoms of a previous concussion. It can lead to severe impairment and even death of the victim.

Legislation (P.L. 2010, Chapter 94) signed on December 7, 2010, mandated measures to be taken in order to ensure the safety of K-12 student-athletes involved in interscholastic sports in New Jersey. It is imperative that athletes, coaches, and parent/guardians are educated about the nature and treatment of sports related concussions and other head injuries. The legislation states that:
- All Coaches, Athletic Trainers, School Nurses, and School/Team Physicians shall complete an Interscholastic Head Injury Safety Training Program by the 2011-2012 school year.
- All school districts, charter, and non-public schools that participate in interscholastic sports will distribute annually this educational fact to all student athletes and obtain a signed acknowledgement from each parent/guardian and student-athlete.
- Each school district, charter, and non-public school shall develop a written policy describing the prevention and treatment of sports-related concussion and other head injuries sustained by interscholastic student-athletes.
- Any student-athlete who participates in an interscholastic sports program and is suspected of sustaining a concussion will be immediately removed from competition or practice. The student-athlete will not be allowed to return to competition or practice until he/she has written clearance from a physician trained in concussion treatment and has completed his/her district’s graduated return-to-play protocol.

Quick Facts
- Most concussions do not involve loss of consciousness
- You can sustain a concussion even if you do not hit your head
- A blow elsewhere on the body can transmit an “impulsive” force to the brain and cause a concussion

Signs of Concussions (Observed by Coach, Athletic Trainer, Parent/Guardian)
- Appears dazed or stunned
- Forgets plays or demonstrates short term memory difficulties (e.g. unsure of game, opponent)
- Exhibits difficulties with balance, coordination, concentration, and attention
- Answers questions slowly or inaccurately
- Demonstrates behavior or personality changes
- Is unable to recall events prior to or after the hit or fall

Symptoms of Concussion (Reported by Student-Athlete)
- Headache
- Nausea/vomiting
- Balance problems or dizziness
- Double vision or changes in vision
- Sensitivity to light/sound
- Feeling of sluggishness or fogging
- Difficulty with concentration, short term memory, and/or confusion
What Should a Student-Athlete do if they think they have a concussion?
- **Don’t hide it.** Tell your Athletic Trainer, Coach, School Nurse, or Parent/Guardian.
- **Report it.** Don’t return to competition or practice with symptoms of a concussion or head injury. The sooner you report it, the sooner you may return-to-play.
- **Take time to recover.** If you have a concussion your brain needs time to heal. While your brain is healing you are much more likely to sustain a second concussion. Repeat concussions can cause permanent brain injury.

What can happen if a student-athlete continues to play with a concussion or returns to play to soon?
- Continuing to play with the signs and symptoms of a concussion leaves the student-athlete vulnerable to second impact syndrome.
- Second impact syndrome is when a student-athlete sustains a second concussion while still having symptoms from a previous concussion or head injury.
- Second impact syndrome can lead to severe impairment and even death in extreme cases.

Should there be any temporary academic accommodations made for Student-Athletes who have suffered a concussion?
- To recover cognitive rest is just as important as physical rest. Reading, texting, testing—even watching movies can slow down a student-athletes recovery.
- Stay home from school with minimal mental and social stimulation until all symptoms have resolved.
- Students may need to take rest breaks, spend fewer hours at school, be given extra time to complete assignments, as well as being offered other instructional strategies and classroom accommodations.

**Student-Athletes who have sustained a concussion should complete a graduated return-to-play before they may resume competition or practice, according to the following protocol:**
- **Step 1:** Completion of a full day of normal cognitive activities (school day, studying for tests, watching practice, interacting with peers) without reemergence of any signs or symptoms. If no return of symptoms, next day advance.
- **Step 2:** Light Aerobic exercise, which includes walking, swimming, and stationary cycling, keeping the intensity below 70% maximum heart rate. No resistance training. The objective of this step is increased heart rate.
- **Step 3:** Sport-specific exercise including skating, and/or running: no head impact activities. The objective of this step is to add movement.
- **Step 4:** Non contact training drills (e.g. passing drills). Student-athlete may initiate resistance training.
- **Step 5:** Following medical clearance (consultation between school health care personnel and student-athlete’s physician), participation in normal training activities. The objective of this step is to restore confidence and assess functional skills by coaching and medical staff.
- **Step 6:** Return to play involving normal exertion or game activity.

For further information on Sports-Related Concussions and other Head Injuries, please visit:
- [www.edc.gov/concussion/sports/index.html](http://www.edc.gov/concussion/sports/index.html)
- [www.nihs.com](http://www.nihs.com)
- [www.ncaa.org/health-safety](http://www.ncaa.org/health-safety)
- [www.bianj.org](http://www.bianj.org)
- [www.atsnj.org](http://www.atsnj.org)
# Asthma Treatment Plan – Student

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

(Please Print)

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Doctor</th>
<th>Parent/Guardian (if applicable)</th>
<th>Emergency Contact</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Phone</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

**HEALTHY (Green Zone)**

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 _______

**CAUTION (Yellow Zone)**

You have **any** of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: ___________

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from _______ to _______

**EMERGENCY (Red Zone)**

Your asthma is getting worse fast:
- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other: ___________

And/or Peak flow below _______

---

**Take daily control medicine(s). Some inhalers may be more effective with a “spacer” – use if directed.**

### MEDICINE
- **Advair® HFA** □ 45, □ 115, □ 230
- **Aerospan™** □ 1, □ 2 puffs twice a day
- **Alvesco®** □ 80, □ 160
- **Dulera®** □ 100, □ 200
- **Flovent®** □ 44, □ 110, □ 220
- **Qvar®** □ 40, □ 80
- **Symbicort®** □ 80, □ 160
- **Advar Diskus®** □ 100, □ 250, □ 500
- **Asmanex® Twinthaler®** □ 110, □ 220
- **Flovent Disks®** □ 50 □ 100 □ 250
- **Pulmicort Flexhaler®** □ 90, □ 180
- **Pulmicort Respules® (Budesonide)** □ 0.25, □ 0.5, □ 1.0, □ 2.0
- **Singulair® (Montelukast)** □ 4, □ 5, □ 10 mg

### HOW MUCH to take and HOW OFTEN to take it:
- 2 puffs twice a day
- 2 puffs every 4 hours as needed
- 1 unit nebulized every 20 minutes
- 1 inhalation twice a day
- 1 inhalation 4 times a day
- 1 unit nebulized every 4 hours as needed
- 1 unit nebulized every 20 minutes
- 2 puffs twice a day
- 2 puffs twice a day
- 2 puffs twice a day
- 1 inhalation twice a day
- 1 inhalation twice a day
- 1 inhalation 4 times a day
- 1 unit nebulized every 4 hours as needed
- 1 unit nebulized every 4 hours as needed
- 1 unit nebulized every 20 minutes
- 1 unit nebulized every 20 minutes
- 2 puffs twice a day
- 2 puffs twice a day
- 2 puffs twice a day

---

**Triggers**

Check all items that trigger your asthma:
- Colds/flu
- Exercise
- Allergens
  - Dust Mites
  - Dust, stuffed animals, carpet
  - Pollen - trees, grass, weeds
  - Mold
  - Pets - animal dander
  - Pets - rodents, cockroaches
- Odors (Irritants)
  - Cigarette smoke & second hand smoke
  - Perfumes, cleaning products, scented products
  - Smoke from burning wood, inside or outside
- Weather
  - Sudden temperature change
  - Extreme weather - hot and cold
  - Ozone alert days
- Foods:
  - ___________
  - ___________
  - ___________
  - ___________
  - ___________
- Other:
  - ___________
  - ___________
  - ___________
  - ___________
  - ___________

---

**Remember to rinse your mouth after taking inhaled medicine.**

If exercise triggers your asthma, take ______ puffs ______ minutes before exercise.

---

**Continue daily control medicine(s) and ADD quick-relief medicine(s).**

### MEDICINE
- **Albuterol MDI (Pro-air® or Proventil® or Ventolin®)** □ 2 puffs every 4 hours as needed
- **Xopenex®** □ 2 puffs every 4 hours as needed
- **Albuterol** □ 1.25, □ 2.5 mg □ 1 unit nebulized every 4 hours as needed
- **Duoneb®** □ 1 unit nebulized every 4 hours as needed
- **Xopenex® (Levalbuterol)** □ 0.31, □ 0.63, □ 1.25 mg □ 1 unit nebulized every 4 hours as needed
- **Combivent Respinat®** □ 1 inhalation 4 times a day

### HOW MUCH to take and HOW OFTEN to take it:
- 2 puffs every 4 hours as needed
- 1 unit nebulized every 4 hours as needed
- 1 unit nebulized every 4 hours as needed
- 1 unit nebulized every 4 hours as needed
- 1 inhalation 4 times a day
- Increase the dose of, or add:
- Other

- If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.

---

**Take these medicines NOW and CALL 911. Asthma can be a life-threatening illness. Do not wait!**

### MEDICINE
- **Albuterol MDI (Pro-air® or Proventil® or Ventolin®)** □ 4 puffs every 20 minutes
- **Xopenex®** □ 4 puffs every 20 minutes
- **Albuterol** □ 1.25, □ 2.5 mg □ 1 unit nebulized every 20 minutes
- **Duoneb®** □ 1 unit nebulized every 20 minutes
- **Xopenex® (Levalbuterol)** □ 0.31, □ 0.63, □ 1.25 mg □ 1 unit nebulized every 20 minutes
- **Combivent Respinat®** □ 1 inhalation 4 times a day

### HOW MUCH to take and HOW OFTEN to take it:
- 4 puffs every 20 minutes
- 1 unit nebulized every 20 minutes
- 1 unit nebulized every 20 minutes
- 1 unit nebulized every 20 minutes
- 1 inhalation 4 times a day

---

**Permission to Self-administer Medication:**
- □ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaler medications named above in accordance with NJ Law.
- □ This student is not approved to self-medicate.

**Physician’s Orders:**

<table>
<thead>
<tr>
<th>PHYSICIAN/APN/PA SIGNATURE</th>
<th>DATE</th>
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**Parent/Guardian Signature:**

**Physician Stamp:**

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Make a copy for parent and for physician file, send original to school nurse or child care provider.
Asthma Treatment Plan — Student

Parent Instructions

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

1. Parents/Guardians: Before taking this form to your Health Care Provider, complete the top left section with:
   - Child’s name
   - Child’s doctor’s name & phone number
   - Parent/Guardian’s name & phone number
   - Child’s date of birth
   - 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

   - Togetheryou and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:
   - Child’s peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
   - Child’s asthma triggers on the right side of the form
   - Permission to Self-administer Medication 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

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child’s health care provider concerning my child’s health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

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<tr>
<th>Parent/Guardian Signature</th>
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FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be ALLOWED to carry the following medication ______________________________ for self-administration in school pursuant to N.J.A.C.:6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ I DO NOT request that my child self-administer his/her asthma medication.

<table>
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