

RAMAPO HIGH SCHOOL

331 George Street, Franklin Lakes, NJ 07417
201-891-1500 (Phone); 201-891-9288 (Fax)

Claudia Dargento
Assistant Principal

Travis H. Smith
Principal

L. Michael Mancino
Assistant Principal

Dear Parents or Guardians:

The following information is provided to you at this time so you may address them during the summer months **PRIOR** to the start of school.

Physicals-

According to New Jersey State Law #NJAC 6A:16-2.2 & NJSA 18A:40-4, a physical examination is required for all incoming 9th graders and/or transfer students. The state physical form can be found on the Ramapo website under the nurse's office tab. The physical is to be within 365 days of the first day of school, signed and stamped by your child's physician.

Please return the completed physicals with the updated immunization record to the Nurse's Office during the summer months. In addition, if your child needs additional treatment plans (allergy/asthma action plan, diabetic or seizure, see Ramapo Nurse's Office at www.rih.org for all forms). Please submit these forms with the physical.

Your child must be in compliance with the New Jersey State Sanitary Code, failure to comply will prevent your child from attending school.

Fall Athletes: Pre-participation Physicals (along with all other forms) are Due by July 15th to the Nurse's Office for sport clearance. Please use regular mail or drop off forms at Main Entrance during summer. (Please do not email forms to the nurse)

Health History Update- Every Athlete needs to hand in a Health Update along with their forms. Each new Sport Season (fall, winter & spring) a New Health Update must be submitted for that sport. The parent completes this form.

Post Covid Clearance Form- This form is for any Athlete that has recently recovered from Covid-19. Due to increased cardiac risk in athletes post covid- your athlete needs to be cleared by their doctor prior to return to sports & PE.

Medication-

We encourage parents and guardians to administer all medication at home. However, at times we understand this may not be possible. **All medication administered at school, requires the medication consent form, to be**

completed by both the parent and physician. The medication consent form must be submitted annually. All medication brought from home must be dispensed by the school nurse and must be in the original pharmacy container with the students full name and date.

Students may **not** self administer or carry over the counter medication. *Only life threatening medications may be self administered with medication orders (such as asthma inhaler, epi-pens & insulin).*

Generally, students do visit the nurse's office and request OTC's (such as Tylenol, Motrin, etc) which require the completed medication consent form.

Thank you Have a great summer!

Kimberly Sikora RN, CSN & Tereena Elias RN, CSN

ramnurse@rih.org

201-891-1500 Option #3

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

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

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

Date of Exam _____
 Name _____ Date of birth _____
 Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

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

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

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

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. 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?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, lightheadedness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
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)?			40. Have you ever become ill while exercising in the heat?		
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?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
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)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			52. Have you ever had a menstrual period?		
			53. How old were you when you had your first menstrual period?		
			54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

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

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

© 2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

PREPARTICIPATION PHYSICAL EVALUATION THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

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

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
6. Do you regularly use a brace, assistive device, or prosthetic?	Yes	No
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

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

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

Explain "yes" answers here

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

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

NOTE: The preparticipation 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

- 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)*		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic*		
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 treatment for _____
- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) _____ Date of exam _____
 Address _____ Phone _____
 Signature of physician, APN, PA _____

PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex M F Age _____ Date of birth _____

Cleared for all sports without restriction

Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

Not cleared

Pending further evaluation

For any sports

For certain sports _____

Reason _____

Recommendations _____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____ (Date)

Approved _____ Not Approved _____

Signature: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

Ramapo Indian Hills High School District

MEDICATION FORM

HAVE DOCTOR FILL IN REQUIRED SECTIONS. PARENTS SIGN FORM AND RETURN COMPLETED FORM TO THE NURSES OFFICE.

STUDENTS NAME: _____ Grade: _____
DATE OF BIRTH: _____ HOME PHONE: _____

The following medication may be administered to my patient _____

DIAGNOSIS: _____ MEDICATION: _____

DOSAGE/ROUTE: _____ TIME TO BE GIVEN: _____

SIGNIFICANT SIDE EFFECTS: _____

Tylenol (acetaminophen) 325 mg: _____ How many: _____
How frequently: _____ PRN: _____

Advil / Motrin (ibuprofen) 200 mg: _____ How many: _____
How frequently: _____ PRN: _____

Cough drops: _____ How many: _____

Tums: _____ How many: _____

Pepto Bismol: _____ How many: _____

How frequently: _____ PRN: _____

Medication taken at home YES: _____ NO: _____

Name of Medication: _____

MD NAME (print): _____

MD SIGNATURE: _____

MD STAMP:

I request for my child, _____, to receive medication as designated above. I have been informed that the school district, its agents, and employees shall incur no liability whatsoever as a result of any untoward reaction arising from the administration of medication to my child. I hereby indemnify and hold harmless the Ramapo Indian Hills Board of Education, its agents, and employees from any and all claims.

DATE: _____ PARENT SIGNATURE: _____

New Jersey Department of Education Health History Update Questionnaire

Name of School: _____

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student's parent or guardian.

Student: _____ Age: _____ Grade: _____

Date of Last Physical Examination: _____ Sport: _____

Since the last pre-participation physical examination, has your son/daughter:

1. Been medically advised not to participate in a sport? Yes No

If yes, describe in detail:

2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes No

If yes, explain in detail:

3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes No

If yes, describe in detail:

4. Fainted or "blacked out?" Yes No

If yes, was this during or immediately after exercise?

5. Experienced chest pains, shortness of breath or "racing heart?" Yes No

If yes, explain

6. Has there been a recent history of fatigue and unusual tiredness? Yes No

7. Been hospitalized or had to go to the emergency room? Yes No

If yes, explain in detail

8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes No

9. Started or stopped taking any over-the-counter or prescribed medications? Yes No

10. Been diagnosed with Coronavirus (COVID-19)? Yes No

If diagnosed with Coronavirus (COVID-19), was your son/daughter symptomatic? Yes No

If diagnosed with Coronavirus (COVID-19), was your son/daughter hospitalized? Yes No

11. Has any member of the student-athlete's household been diagnosed with Coronavirus (COVID-19)? Yes No

Date: _____ Signature of parent/guardian: _____

Please Return Completed Form to the School Nurse's Office

Ramapo Indian Hills Regional High School District

Nursing Department

=====

Post Covid Clearance

Name of Student/Athlete _____

Date of Positive Test or Onset of Symptoms _____

Severity of Symptoms

(Please Choose)

Mild

Asymptomatic or mildly symptomatic (< 4 days of fever > 100.4°F, < 1 week of myalgia, chills and lethargy)

Moderate

> 4 days of fever > 100.4°F, > 1 week of myalgia, chills, lethargy, or a non-ICU hospital stay and no evidence of multisystem inflammatory syndrome. EKG & cardiology consult recommended.

Severe

(ICU stay and/or intubation) or multisystem inflammatory syndrome. It is recommended they be restricted from exercise for a minimum of 3 to 6 months and obtain cardiology clearance prior to resuming training or competition.

Student/Athlete:

Medically eligible for sports without restrictions

Not medically eligible for any sports, pending further evaluation

Physician Signature/Stamp

Date: _____