

# New Jersey Department of Education ANNUAL PHYSICAL EXAMINATION FORM

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

## Part A: HEALTH HISTORY QUESTIONNAIRE

**\*\* Date of Last Physical:** \_\_\_\_\_

**North Hunterdon High School**

Student's Name: \_\_\_\_\_ Sex: M F (circle one) Age: \_\_\_\_ Grade: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Parent e-mail: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Medical Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name of parent/guardian: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

Name of parent/guardian: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

Additional emergency contact: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Phone (work): \_\_\_\_\_ Phone (home): \_\_\_\_\_ Phone (cell): \_\_\_\_\_

Name of **Sport** \_\_\_\_\_ Name of **Intramural** \_\_\_\_\_ Name of **Activity** \_\_\_\_\_

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

**1. Have you ever had, or do you currently have:**

- |  |                           |
|--|---------------------------|
| a. Restriction from sports for a health related problem?   | Y / N / Don't Know        |
| b. An injury or illness since your last exam?  | Y / N / Don't Know        |
| c. A chronic or ongoing illness (such as diabetes or asthma)?  | Y / N / Don't Know        |
| (1.) An <b>INHALER</b> or other prescription medicine to control asthma?   | Y / N / Don't Know        |
| d. Any prescribed or over the counter <b>medications (list below)</b> that you take on a regular basis?                        | Y / N / Don't Know        |
| e. Surgery, hospitalization or any emergency room visit(s)?  | Y / N / Don't Know        |
| f. Any <b>allergies</b> to medications?  | <b>Y / N / Don't Know</b> |
| g. Any <b>allergies</b> to bee stings, pollen, latex or foods?   | <b>Y / N / Don't Know</b> |
| (1.) If yes, check type of reaction:   |                           |
| <input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Breathing or other anaphylactic reaction |                           |
| (2.) Take any medication / <b>EPIPEN</b> taken for allergy symptoms? (List below.)   | Y / N / Don't Know        |
| h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders?                         | Y / N / Don't Know        |
| i. A blood relative who died before age 50?  | Y / N / Don't Know        |

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

\_\_\_\_\_

**List all medications here:**

Medication Name	Dosage	Frequency

Student Name: \_\_\_\_\_

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

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

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

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

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

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

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

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

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

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

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

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

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Student Name: \_\_\_\_\_

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

- a. Difficulty breathing?
  - (1.) During exercise? Y / N / Don't Know
  - (2.) After running one mile? Y / N / Don't Know
  - (3.) Coughing, wheezing or shortness of breath in weather changes? Y / N / Don't Know
  - (4.) Exercise-induced asthma? Y / N / Don't Know
    - i. Controlled with medication? (specify \_\_\_\_\_) Y / N / Don't Know
    - ii. Experience dizziness, passing out or fainting? Y / N / Don't Know
- b. Viral infections (e.g. mono, hepatitis, coxsackie virus)? Y / N / Don't Know
- c. Become tired more quickly than other? Y / N / Don't Know
- d. Any of the following skin conditions:
  - (1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts? Y / N / Don't Know
  - (2.) Sun sensitivity? Y / N / Don't Know
- e. Weight gain/loss (of 10 pounds or more)? Y / N / Don't Know
  - (1.) Do you want to weigh more or less than you do now? Y / N / Don't Know
- f. Ever had feelings of depression? Y / N / Don't Know
- g. Heat-related problems (dehydration, dizziness, fatigue, headache)? Y / N / Don't Know
  - (1.) Heat exhaustion (cool, clammy, damp skin)? Y / N / Don't Know
  - (2.) Heat stroke (hot, red, dry skin)? Y / N / Don't Know
  - (3.) Muscle cramps? Y / N / Don't Know
- h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? Y / N / Don't Know

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

\_\_\_\_\_  
\_\_\_\_\_

7. Females only:

Age of onset of menstruation: \_\_\_\_\_ How many menstrual periods in the last twelve (12) months? \_\_\_\_\_

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

8. Males only:

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

PARENT / GUARDIAN SIGNATURE

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

**X** \_\_\_\_\_  
Signature, Parent/Guardian or Student Age 18

\_\_\_\_\_  
Date of Signature

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

*{NOTE Athletics/Intramurals (Part A1-3) will need to be completed and submitted for each sport season or intramural}*

**ANNUAL PHYSICAL EVALUATION FORM**  
**Part B: Physical Evaluation Form**  
(Completed by the examining licensed provider MD, DO, APN or PA)

**-STUDENT INFORMATION-**

**Student's Name:** \_\_\_\_\_ **Sport / Intramural or Activity:** \_\_\_\_\_

Sex: M F (circle one) Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School: **North Hunterdon High School**

**- EXAMINING PHYSICIAN / PROVIDER CONTACT INFORMATION-**

If conducted by school physician check here

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**FINDINGS OF PHYSICAL EVALUATION *Please note : All Fields Must be Completed***

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_ bpm.

Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y / N Contacts: Y / N Glasses: Y / N

**\* Students with vision > 20/40 in one eye, need additional clearance by an eye specialist before participation in sports / intramurals \***

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

Student Name: \_\_\_\_\_

**Most recent immunizations and dates administered:**


**Medications currently prescribed, with dose and frequency:**

Medication Name	Dosage	Frequency
EPIPEN            Yes        No	Requires school form	
INHALER           Yes        No	Requires school form	

**ALLERGIES**    Yes    No    Please List: \_\_\_\_\_

**Additional Observations:** \_\_\_\_\_

**General Diagnosis:** \_\_\_\_\_

**General Recommendations:** \_\_\_\_\_

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



Student Name: \_\_\_\_\_

**HEALTH HISTORY (Part A 1-3) REVIEWED AND STUDENT EXAMINED BY: (Physician's/Provider's Stamp)**

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

PHYSICIAN'S/PROVIDER'S SIGNATURE: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Exam Date: \_\_\_\_\_

**RESERVED FOR SCHOOL DISTRICT USE**

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

History and Physical Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

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

Medical Eligibility Notification Sent to Parent/Guardian by School Physician      Date: \_\_\_\_\_

Letter of notification is attached.

OR

Parent notification indicates that:

- Participation Approved without limitations.
- Participation Approved with limitations pending evaluation.
- Participation NOT Approved.

Reason (s) for Disapproval :

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