

GLEN ROCK PUBLIC SCHOOLS

HIGH SCHOOL/MIDDLE SCHOOL
HEALTH OFFICE



400 HAMILTON AVENUE
GLEN ROCK, NJ 07452-2398
PH: (201) 445-7700 EXT. 8920
FAX: (201) 389-5048

Dear Parent/Guardian:

Good health is an important factor in your child's ability to secure the maximum benefits from education. In order that we may have better knowledge of the health of our students, and in accordance with New Jersey law and the Board of Education policy, each student must be examined upon entry into the school district. This examination must be done no more than 365 days *prior* to entry, and must state what, if any, modifications are required for full participation in the school program.

Each student's medical examination must be conducted by a healthcare provider chosen by the student's parent/guardian(s) at the provider's facility (the student's medical home). If the student does not have a medical home, arrangements may be made for the examination to take place at the school physician's office.

Kindly have the Physical Form completed by your child's physician and return it to the Health Office as soon as possible. This form must be received no later than thirty (30) days after entering the district.

If you have any questions, please call the Health Office.

Thank you for your cooperation.

Robin Leone, RN, CSN
High School

Stephanie Nerney, RN, CSN
Middle School

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HEALTH HISTORY

TO BE COMPLETED BY PARENT / GUARDIAN

Name: _____ Grade: _____

Date of Birth: _____ Place of Birth: _____

COMMUNICABLE DISEASE HISTORY (indicate month and year)

Chickenpox _____ German Measles _____ Strep throat _____

Measles _____ Scarlet Fever _____ Other _____

DISEASE HISTORY (indicate month and year of onset/episode)

Diabetes: _____ Urinary Tract/Kidney: _____

Convulsive Disorder: _____

Growth and Development Problems (type): _____

Skeletal/Joint Problems (type): _____

Asthma: _____ Allergies: _____

Hearing Deficit: _____ Vision Deficit: _____

Hospitalization (reason for and date): _____

Is your child receiving treatment for any condition? _____

Does your child require medication? _____

Is there any health concern you would like known in the Health Office? _____

I hereby authorize the release of pertinent medical information to be exchanged among appropriate professional staff involved in the care of the above named student.

Signature: _____ Date: _____

Parent/Guardian

GLEN ROCK PUBLIC SCHOOLS

MIDDLE SCHOOL
STEPHANIE NERNEY, RN, CSN
NERNEYS@GLENROCKNJ.ORG
PH: (201) 445-7700 EXT. 8920
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HIGH SCHOOL
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MIDDLE & HIGH SCHOOL HEALTH OFFICE

Dear Parents/Guardians:

Documentation that your child has received the required immunizations in order to begin 6th grade or subsequent grades needs to be submitted with the other medical information required.

This is a reminder informing you that the New Jersey Department of Health and Senior Services (DHSS) has recently revised the administrative rules with substantive changes to include the requirement of new vaccines for students attending sixth grade. The amended regulations state the following:

Every child born on or after January 1, 1997 and entering grade six on or after September 1, 2008 shall have received one (1) dose of Tdap given no earlier than the 10th birthday.

Children entering or attending grade six on or after September 1, 2008 who received a TD booster within the last 5 years shall not be required to receive a Tdap dose until five (5) years have elapsed from the last DTP/Dtap or Td injection.

Every child born on or after January 1, 1997 and entering or attending grade six on or after September 1, 2008 shall have received one (1) dose of a meningococcal-containing vaccine, such as the medically-preferred meningococcal conjugate vaccine.

The completed paperwork must be brought to the health office as soon as possible. Please make a copy of your documents prior to submitting them. Please speak with your physician regarding any questions. Thank you for your cooperation in this matter.

Student Name: _____

Date: _____

Date of Birth: _____

The above named student has received:

1. Tdap booster on: _____
Month/Day/Year

2. Meningococcal vaccine: _____
Month/Day/Year

Signature of Primary Provider

Print or Stamp of Primary Provider

GLEN ROCK PUBLIC SCHOOLS

IMMUNIZATION RECORD

Grades Pre-K – 12

Student Name: _____ Date of Birth: _____

Vaccine Type	Disease Date	1 st Dose Mo/Day/Yr	2 nd Dose Mo/Day/Yr	3 rd Dose Mo/Day/Yr	4 th Dose Mo/Day/Yr	5 th Dose Mo/Day/Yr	Mo/Day/Yr
Diphtheria, Tetanus, Pertussis vaccine (DTaP) or any combination of Td or DT							
Tdap (1 dose after 10 years old)							
Inactive Poliovirus (IPV) if oral vaccine, indicate OPV							
HIB (Haemophilus B conjugate vaccine)							
Prevnar (Pneumococcal conjugate Vaccine – PCV)							
Influenza							
MMR							
Measles					Measles Serology	Date:	Titer:
Mumps					Mumps Serology	Date:	Titer:
Rubella					Rubella Serology	Date:	Titer:
Varicella			Disease Date:		Varicella Serology	Date:	Titer:
Hepatitis B (3 doses)							
Hepatitis A (2 doses)							
Menactra (1 dose)							
Gardasil (HBV 3 doses)							

Medical Exemption Attached/Date: _____ Religious Exemption Attached/Date: _____

TB Screening (Mantoux Test)

	Date	Date	Date
Tested			
Read			
Result (mm)			

Signature of Licensed Medical Provider

Date

Complete this form for each student entering the district regardless of anticipated participation in school athletics.

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, tightness, 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 _____

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■ PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

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

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

Explain "yes" answers here

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

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

Explain "yes" answers here

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

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

■ 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:

Date Reviewed: _____

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 _____

NOTE: The Preparticipation Physical Examination must be conducted by a health-care provider who 1) is a licensed physician, advanced practitioner nurse, or physician assistant; and 2) completed by 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 <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 		
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 		
Lymph nodes		
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 		
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis 		
Neurologic ^c		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional <ul style="list-style-type: none"> Duck-walk, single leg hop 		

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
^bConsider GU exam if in private setting. Having third party present is recommended.
^cConsider 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 _____
 Address _____ Phone _____
 Signature of physician, APN, PA _____