HOPATCONG HIGH SCHOOL
ATHLETIC DEPARTMENT

ANNUAL ATHLETIC PARTICIPATION FORM

Dear Parent/Guardian:

Step 1 – PLEASE COMPLETE
Bring this entire packet to your physician's office. Have physician fill out paperwork in its entirety. After you get your physical with your physician, please return all completed physical forms, within this packet to the main office in order to be processed by the school nurse and athletic office.

Step 2 – READ ONLY (DO NOT PRINT THESE FORMS)
Please read:

- NJSIAA Covid-19 Protocol
- NJSIAA Concussion Policy
- Hopatcong BOE Concussion Policy
- HHS Concussion Protocol
- Hopatcong BOE Random Drug Testing Policy
- NJSIAA Steroid Testing Policy
- Sudden Cardiac Death in Young Athletes Information
- Sports-Related Eye Injuries Information
- Opioid Use and Misuse Information

By signing below, I acknowledge I have completed, read, and understand all information stated in Step 1 and Step 2 above.

Print Student/Athlete Name _____ Parent Signature _____

Print Parent Name _____ Date _____

updated:
4/24/23

Physical Date_____ Nurse_____
Guidance_____ #_____
AD_____

HOPATCONG HIGH SCHOOL
ATHLETIC PARTICIPATION FORM

ATHLETE'S NAME:_____ GRADE_____

ADDRESS:_____

DATE OF BIRTH:_____ PLACE OF BIRTH:_____

I hereby consent for my child to compete in _____ for the 20____ season.
SPORT

I give my permission for him / her to practice, play and travel as a member of this team. I realize that such activities involve the potential of injury. I acknowledge that even with the best coaching, the most advance protection equipment, and strict observation of rules, injuries can be severe.

I also realize that when medical attention is necessary, the Hopatcong Board of Education insurance may only pay for the portion not covered by my insurance company. ("In Excess Policy")

My insurance company is _____

Policy Number:_____

If, for some reason, I lose my insurance coverage, I will notify the school at once in writing of this loss of coverage.

My son / daughter has had the following medical problems. (Please mark with an X)

- ☐ Recent history of fatigue, undue tiredness
- ☐ Athletic injuries (sprain, fracture, dislocation)
- ☐ Head injury (concussion, loss of consciousness, Frequent headaches)
- ☐ Neurological problems (seizures, fainting spells)
- ☐ Heart problems (murmur, high or low blood pressure, palpitations, frequent chest pains
- ☐ History of family member having a sudden death
- ☐ Allergies (hives, asthma, bee stings)
- ☐ Surgery
- ☐ Medication on regular basis and reason
- ☐ Medically advised not to participate in a specific sport
- ☐ Physician's care now and reason

Please comment more fully and give dates for any of the above marked with an X, also any hospitalizations, etc.

DATE:_____ SIGNATURE:_____
(Parent / Guardian)

HOME PHONE:_____ BUSINESS PHONE:_____

I understand that in order to participate in _____ I must:
SPORT

1. Have passed a comprehensive medical examination given by the school's physician or my family doctor.
2. Have on file with the School Nurse written proof of this medical examination.
3. Have read the Hopatcong Athletic Handbook and will abide by all rules and regulations explained in the handbook.
4. Be academically eligible in accordance with Hopatcong High School and State regulations (refer to Handbook).

Date _____ Student's Signature _____

PHYSICIAN'S USE ONLY

I have completed a comprehensive physical on the above named student and found his / her physical condition such that he / she **MAY / MAY NOT PARTICIPATE IN INTERSCHOLASTIC SPORTS.**

Date _____ Physician's Signature _____

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 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
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
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)?		
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?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

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

EVALUACIÓN FÍSICA – PRE-PARTICIPACIÓN

FORMULARIO DE HISTORIAL MÉDICO

(Nota: Este formulario debe ser rellenado por el paciente y padre/madre antes de ver al doctor. El doctor debe mantener este formulario en el expediente)

Fecha del examen _____

Nombre _____ Fecha de nacimiento _____

Sexo _____ Edad _____ Grado _____ Escuela _____ Deporte(s) _____

Medicamentos y Alergias: Por favor, indica todos los medicamentos con y sin receta médica y suplementos (herbales y nutricionales) que estás tomando actualmente

_____

_____

_____

Tienes alergias ☐Sí ☐No Si la respuesta es sí, por favor identifica abajo la alergia específica.
☐Medicamentos ☐Polen ☐Comida ☐Picaduras de insecto

Explica abajo las preguntas respondidas con un "sí". Pon un círculo alrededor de las preguntas cuyas respuestas desconoces.

PREGUNTAS GENERALES	Sí	No
1. ¿Alguna vez un doctor te ha prohibido o limitado tu participación en deportes por alguna razón?		
2. ¿Tienes actualmente alguna condición médica? Si es así, por favor identifícala abajo: ☐Asma ☐Anemia ☐Diabetes ☐Infecciones Otro: _____		
3. ¿Has sido ingresado alguna vez en el hospital?		
4. ¿Has tenido cirugía alguna vez?		
PREGUNTAS SOBRE LA SALUD DE TU CORAZÓN	**Sí**	**No**
5. ¿Te has desmayado alguna vez o casi te has desmayado DURANTE o DESPUÉS de hacer ejercicio?		
6. ¿Has tenido alguna vez molestias, dolor o presión en el pecho cuando haces ejercicio?		
7. ¿Alguna vez has sentido que tu corazón se acelera o tiene latidos irregulares cuando haces ejercicio?		
8. ¿Te ha dicho alguna vez un doctor que tienes un problema de corazón? Si es así, marca el que sea pertinente ☐Presión alta ☐Un soplo en el corazón ☐Nivel alto de colesterol ☐Una infección en el corazón ☐Enfermedad de Kawasaki ☐Otro:		
9. ¿Alguna vez un doctor te ha pedido que te hagas pruebas de corazón? (Por ejemplo, ECG/EKG, ecocardiograma)		
10. ¿Te sientes mareado o te falta el aire más de lo esperado cuando haces ejercicio?		
11. ¿Has tenido alguna vez una convulsión inexplicable?		
12. ¿Te cansas más o te falta el aire con más rapidez que a tus amigos cuando haces ejercicio?		

PREGUNTAS SOBRE LA SALUD DEL CORAZÓN DE TU FAMILIA	Sí	No
13. ¿Has tenido algún familiar que ha fallecido a causa de problemas de corazón o que haya fallecido de forma inexplicable o inesperada antes de la edad de 50 años (incluyendo ahogo, accidente de tráfico inesperado, o síndrome de muerte súbita infantil)?		
14. ¿Sufre alguien en tu familia de cardiomiopatía hipertrófica, síndrome Marfan, cardiomiopatía arritmogénica ventricular derecha, síndrome de QT corto, síndrome de Brugada, o taquicardia ventricular polimórfica catecolaminérgica?		
15. ¿Alguien en tu familia tiene problemas de corazón, un marcapasos o un desfibrilador implantado en sucorazón?		
16. ¿Ha sufrido alguien en tu familia un desmayo inexplicable, convulsiones inexplicables, o casi se ha ahogado?		
PREGUNTAS SOBRE HUESOS Y ARTICULACIONES	**Sí**	**No**
17. ¿Alguna vez has perdido un entrenamiento o partido porque te habías lesionado un hueso, músculo, ligamento o tendón?		
18. ¿Te has roto o fracturado alguna vez un hueso o dislocado una articulación?		
19. ¿Has sufrido alguna vez una lesión que haya requerido radiografías, resonancia (MRI) tomografía, inyecciones, terapia, un soporte ortopédico/tablilla, un yeso, o muletas?		
20. ¿Has sufrido alguna vez una fractura por estrés?		
21. ¿Te han dicho alguna vez que tienes o has tenido una radiografía para diagnosticar inestabilidad del cuello o inestabilidad atlantoaxial? (Síndrome de Down o enanismo)		
22. ¿Usas regularmente una tabilla/soporte ortopédico, ortesis, u otro dispositivo de asistencia?		
23. ¿Tienes una lesión en un hueso, músculo o articulación que te esté molestando?		
24. ¿Algunas de tus articulaciones se vuelven dolorosas, inflamadas, se sienten calientes, o se ven enrojecidas?		
25. ¿Tienes historial de artritis juvenil o enfermedad del tejido conectivo?		

(Por favor, continúe)

PREGUNTAS MÉDICAS	Sí	No
26. ¿Toses, tienes silbidos o dificultad para respirar durante o después de hacer ejercicio?		
27. ¿Has usado alguna vez un inhalador o has tomado medicamento para el asma?		
28. ¿Hay alguien en tu familia que tenga asma?		
29. ¿Naciste sin o te falta un riñón, un ojo, un testículo (varones), el bazo, o algún otro órgano?		
30. ¿Tienes dolor en la ingle o una protuberancia o hernia dolorosa en el área de la ingle?		
31. ¿Has tenido mononucleosis (mono) infecciosa en el último mes?		
32. ¿Tienes algún sarpullido, llagas, u otros problemas en la piel?		
33. ¿Has tenido herpes o infección de SARM en la piel?		
34. ¿Has sufrido alguna vez una lesión o contusión en la cabeza?		
35. ¿Has sufrido alguna vez un golpe en la cabeza que te haya producido una confusión, dolor de cabeza prolongado, o problemas de memoria?		
36. ¿Tienes un historial de un trastorno de convulsiones?		
37. ¿Tienes dolores de cabeza cuando haces ejercicio?		
38. ¿Has tenido entumecimiento, hormigueo, o debilidad en los brazos o piernas después de haber sufrido un golpe o haberte caído?		
39. ¿Has sido alguna vez incapaz de mover los brazos o las piernas después de haber sufrido un golpe o haberte caído?		
40. ¿Te has enfermado alguna vez al hacer ejercicio cuando hace calor?		
41. ¿Tienes calambres frecuentes en los músculos cuando haces ejercicio?		
42. ¿Tienes tú o alguien en tu familia el rasgo depranocítico o la enfermedad drepanocítica?		
43. ¿Has tenido algún problema con los ojos o la vista?		
44. ¿Has sufrido alguna lesión o daño en los ojos?		
45. ¿Usas lentes o lentes de contacto?		
46. ¿Usas protección para los ojos, tal como lentes protectoras o un escudo facial?		
47. ¿Te preocupa tu peso?		
48. ¿Estás intentando aumentar o perder de peso o alguien te ha recomendado que lo hagas?		
49. ¿Estás siguiendo alguna dieta especial o evitas ciertos tipos de comida?		
50. ¿Has tenido alguna vez un trastorno alimenticio?		
51. ¿Tienes alguna preocupación de la que quieras hablar con el doctor?		

SÓLO PARA MUJERES	Sí	No
52. ¿Has tenido alguna vez el período menstrual?		
53. ¿Qué edad tenías cuando tuviste tu primer período menstrual?		
54. ¿Cuántos períodos has tenido en los últimos 12 meses?		

Explica aquí las preguntas a las que respondiste con un "sí"

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Yo por la presente declaro que, según mi más leal saber y entender, mis respuestas a las preguntas anteriores están completas y son correctas.

Firma del atleta _____

Firma del padre/madre/tutor legal _____

Fecha _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

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 _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

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

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		
Height _____ Weight _____ ☐ Male ☐ Female		
BP ____/____ (____/____) Pulse _____ Vision R 20/____ L 20/____ Corrected ☐ Y ☐ 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[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[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.

☐ 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 _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

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 _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

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 ☐

Date: _____ Signature of parent/guardian: _____

Please Return Completed Form to the School Nurse's Office

9/28/22

Cuestionario de actualización del historial médico del Departamento de Educación de Nueva Jersey

Nombre de Escuela: _____

Para participar en un equipo o escuadrón atlético interescolar o intramuros patrocinado por la escuela, cada estudiante cuyo examen físico se completó más de 90 días antes del primer día de práctica oficial deberá proporcionar un cuestionario de actualización del historial médico completado y firmado por el padre o tutor del estudiante.

Estudiante: _____ Edad: _____ Grado: _____

Fecha del último examen físico: _____ Deporte: _____

Desde el último examen físico previo a la participación, ¿su hijo / a:

1. ¿Se le ha recomendado médicamente que no participe en un deporte? Si ☐ No ☐

   En caso afirmativo, describa en detalle:

2. ¿Ha sufrido una conmoción cerebral, ha estado inconsciente o ha perdido la memoria por un golpe en la cabeza? Si ☐ No ☐

   En caso afirmativo, explique en detalle:

3. ¿Se ha roto un hueso o se ha torcido / dislocado / dislocado algún músculo o articulación?

   Si ☐ No ☐

   En caso afirmativo, describa en detalle:

4. ¿Desmayado? Si ☐ No ☐

   ¿En caso afirmativo, fue durante o inmediatamente después del ejercicio?

5. ¿Dolor en el pecho, dificultad respiratoria o "corazón acelerado?" Sí ☐ No ☐

   En caso afirmativo, describa:

6. ¿Ha habido antecedentes recientes de fatiga y cansancio inusual? Sí ☐ No ☐

7. ¿Ha sido hospitalizado o ha tenido que ir a urgencias? Si ☐ No ☐

   Si es sí, explíquelo en detalle:

8. Desde el último examen físico, ¿ha habido una muerte súbita en la familia o algún miembro de la familia menor de 50 años ha tenido un ataque cardíaco o "problemas cardíacos"? Sí ■ No ☐

9. ¿Comenzó o dejó de tomar algún medicamento recetado o de venta libre? Sí ☐ No ☐

10. ¿Le han diagnosticado Coronavirus (COVID-19)? Sí ☐ No ☐

    Si se le diagnosticó Coronavirus (COVID-19), ¿su hijo/a tuvo síntomas? Sí ☐ No ☐

    Si le diagnosticaron Coronavirus (COVID-19), ¿fue hospitalizado su hijo/a? Sí ☐ No ☐

Fecha: _____ Firma del padre / tutor: _____

Devuelva el formulario completo a la enfermería de la escuela.

HOPATCONG HIGH SCHOOL
Hopatcong, New Jersey

TO: Parents/Guardians of Students Representing Hopatcong High School in Athletics/Activity Programs

It is exceedingly difficult to obtain medical services for students injured when competing without first obtaining written parental/guardian consent. So that proper emergency assistance may be provided, we ask that you review the following statement, sign it, and return it to the faculty member in charge. It should be understood that if this form is not signed by the parent/guardian, in the event medical attention/hospitalization is necessary, the faculty member or designee shall attempt to locate the parent/guardian and, absent an emergency, treatment may not be rendered.

I hereby authorize the Hopatcong Borough School District and its faculty members in charge of my child named below, to obtain all necessary medical care for my child, and I hereby authorize my licensed physician and/or medical personnel to render all necessary medical treatment to my child.

(Student's Name) (Parent/Guardian Signature) (Date)

Family Doctor _____

Doctor's Phone # _____

Parent's Phone # _____ Alternate # _____

This student's allergies, medical problems, or medications are:

This is a voluntary form. The parent/guardian does not have to complete this form in order for the student to participate.

Hopatcong Borough Schools
Stephanie Martinez, Principal
Hopatcong High School
973-770-8850

Consent to Participate in Random Testing for Student Alcohol or Other Drug Use Program

Student Name (Please Print)_____Grade_____

We hereby consent to permit the above named student to participate in the **Random Testing for Student Alcohol or Other Drug Use Program** as approved by the Hopatcong School District. In issuing consent, we permit the student above named to undergo saliva testing for the presence of alcohol or other drugs as outlined in district policy.

We understand that a qualified vendor will oversee the collection process.

We understand that any saliva samples will be sent only to a certified laboratory for testing and that the samples will be coded to provide confidentiality.

We hereby give consent to the vendor selected by the Hopatcong School District to perform saliva testing for the presence of alcohol or other drugs as named in district policy.

We further give permission to the vendor selected by the Hopatcong School District to release all results of these tests to the Medical Review Officer working for the vendor. We understand these results will be forwarded to the Building Principal and will also be made available to us.

We understand that this consent agreement will be in effect for a period of twelve months from the date listed below.

We understand that the analysis of the specimen conducted will include the following substances and be based on the following levels. See: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5330962/ and https://www.alliance2020.com/wp-content/uploads/Drug-Testing-Cutoff-Levels.pdf and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6807119/ Although the below table identifies the normal set of drugs tested, Policy 5536 suggests this list can be limited when the sample size must be expanded.

Substance	Screen/Initial Level	Confirmation Level
AMPHETAMINES	500 ng/ml	250 ng/ml
COCAINE METABOLITE	300 ng/ml	150 ng/ml
ETHANOL	40 ng/ml	21 ng/ml
MARIJUANA METABOLITE	50 ng/ml	20 ng/ml
OPIATES	2000 ng/ml	2000 ng/ml
OXYCODONES	100 ng/ml	50 ng/ml
PHENCYCLIDINE	25 ng/ml	25 ng/ml

Student Signature: _____Date: _____

Parent Signature: _____Date: _____

Hopatcong Borough Schools
Stephanie Martinez, Principal
Hopatcong High School
973-770-8850

Consentimiento para participar en pruebas aleatorias para el programa de uso de alcohol u otras drogas para estudiantes

Nombre del estudiante (letra de imprenta)_____Grado_____

Por la presente damos nuestro consentimiento para permitir que el estudiante mencionado anteriormente participe en las **Pruebas aleatorias para el programa de consumo de alcohol u otras drogas de los estudiantes** según lo aprobado por el Distrito Escolar de Hopatcong. Al emitir el consentimiento, permitimos que el estudiante mencionado anteriormente se someta a pruebas de saliva para detectar la presencia de alcohol u otras drogas, como se describe en la política del distrito.

Entendemos que un proveedor calificado supervisará el proceso de recolección.

Entendemos que cualquier muestra de saliva se enviará sólo a un laboratorio certificado para su análisis y que las muestras se codificarán para brindar confidencialidad.

Por la presente damos consentimiento al proveedor seleccionado por el Distrito Escolar Hopatcong para realizar pruebas de saliva para detectar la presencia de alcohol u otras drogas como se indica en la política del distrito.

Además, damos permiso al proveedor seleccionado por el Distrito Escolar de Hopatcong para divulgar todos los resultados de estas pruebas al Oficial de Revisión Médica que trabaja para el proveedor. Entendemos que estos resultados se enviarán al director del edificio y también estarán disponibles para nosotros.

Entendemos que este acuerdo de consentimiento estará vigente por un período de doce meses a partir de la fecha que se indica a continuación.

Entendemos que el análisis del espécimen realizado incluirá las siguientes sustancias y se basará en los siguientes niveles. Ver: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5330962/ y https://www.alliance2020.com/wp-content/uploads/Drug-Testing-Cutoff-Levels.pdf y https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6807119/ Aunque la siguiente tabla identifica el conjunto normal de medicamentos analizados, la Política 5536 sugiere que esta lista puede limitarse cuando se debe ampliar el tamaño de la muestra.

Sustancia	Pantalla/Nivel inicial	Nivel de confirmación
ANFETAMINAS	500ng/ml	250ng/ml
METABOLITO DE COCAÍNA	300ng/ml	150ng/ml
ETANOL	40ng/ml	21ng/ml
METABOLITO DE LA MARIHUANA	50ng/ml	20ng/ml
OPIÁCEOS	2000ng/ml	2000ng/ml
OXICODONAS	100ng/ml	50ng/ml
FENCICLIDINA	25ng/ml	25ng/ml

Firma del estudiante: _____Fecha: _____

Firma de los padres: _____Fecha: _____

HOPATCONG BOROUGH SCHOOLS
HOPATCONG HIGH SCHOOL
PO BOX 1029
HOPATCONG, NEW JERSEY 07843
(973) 398-8803

STEPHANIE MARTINEZ
PRINCIPAL

Use and Misuse of Opioid Drugs Fact Sheet

Student-Athlete and Parent/Guardian Sign-Off

In accordance with *N.J.S.A.* 18A:40-41.10, public school districts, approved private schools for students with disabilities, and nonpublic schools participating in an interscholastic sports program must distribute this *Opioid Use and Misuse Educational Fact Sheet* to all student-athletes and cheerleaders. In addition, schools and districts must obtain a signed acknowledgement of receipt of the fact sheet from each student-athlete and cheerleader, and for students under age 18, the parent or guardian must also sign.

This sign-off sheet is due to the Main Office prior to the first official practice session of the athletic season and annually thereafter prior to the student-athlete's or cheerleader's first official practice of the school year.

Name of School: **Hopatcong High School**

Name of School District (If applicable): **Hopatcong Borough Schools**

I/We acknowledge that we received and reviewed the Educational Fact Sheet on the Use and Misuse of Opioid Drugs.

Student Signature: _____

Sport: _____ Grade: _____

Parent/Guardian Signature: (also needed if student is under age 18): _____

Date: _____

[El Departamento de Educación de Nueva Jersey elaboró, en enero de 2018, esta plantilla del Formulario de confirmación para los alumnos atletas con el objetivo de ayudar a las escuelas a adherirse a la ley estatal que requiere que los alumnos atletas (y sus padres o tutores si el alumno es menor de edad) confirmen que recibieron una Ficha informativa sobre opioides de la escuela. Los distritos escolares, las escuelas privadas aprobadas para alumnos con discapacidades y las escuelas no públicas que participan en un programa interescolar de deportes o de porristas deben insertar aquí el membrete del distrito o de la escuela.]

Ficha informativa sobre el consumo y el abuso de medicamentos opioides

Firma del alumno atleta y del padre, madre o tutor

En conformidad con el Título 18A, Artículos 40-41.10 de las Leyes comentadas de Nueva Jersey (New Jersey Statutes Annotated, *N.J.S.A.)*, los distritos escolares públicos, las escuelas privadas aprobadas para alumnos con discapacidades y las escuelas no públicas que participan en un programa deportivo interescolar deben distribuir esta *Opioid Use and Misuse Educational Fact Sheet (Ficha informativa educativa sobre el consumo y el abuso de opioides)* a todos los alumnos atletas y porristas. Además, las escuelas y los distritos deben obtener un acuse de recibo firmado de la ficha informativa de cada alumno atleta y porrista; en el caso de los alumnos menores de 18 años, también debe firmar el padre, la madre o el tutor.

El personal escolar adecuado necesita este formulario de confirmación de acuerdo con lo determinado en su distrito antes de la primera sesión de práctica oficial de la temporada atlética de la primavera de 2018 (2 de marzo de 2018, según lo determina la Asociación Atlética Interescolar del Estado de Nueva Jersey) y, a partir de entonces, de forma anual, antes de la primera práctica oficial del año escolar del alumno atleta o porrista.

Nombre de la escuela: _____

Nombre del distrito escolar (si corresponde): _____

Reconozco (reconocemos) que he (hemos) recibido y revisado la Ficha informativa educativa sobre el consumo y el abuso de medicamentos opioides.

Firma del (de la) alumno(a): _____

Firma del padre, madre o tutor (también es necesaria si el alumno es menor de 18 años)

_____

Fecha: _____

[1]No incluye clubes deportivos ni eventos internos.

State of New Jersey
DEPARTMENT OF EDUCATION

Sudden Cardiac Death Pamphlet

Sign-Off Sheet

Name of School District:_____

Name of Local School: _____

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

Student Signature:_____

Parent or Guardian
Signature:_____

Date:_____

STATE OF NEW JERSEY
DEPARTMENT OF EDUCATION

Folleto sobre muerte cardíaca súbita
Hoja de firma

Nombre del distrito escolar: _____

Nombre de la escuela local: _____

Reconozco / reconocemos que recibimos y revisamos el folleto Muerte cardíaca súbita en atletas jóvenes.

Firma del alumno: _____

Firma del padre o tutor: _____

Fecha: _____