HOPATCONG HIGH SCHOOL
ATHLETIC DEPARTMENT

ANNUAL PHYSICAL PACKET

All students wishing to participate in Athletics at Hopatcong High School must complete all parts of the registration process.

Step 1 Hopatcong ATHLETICS PHYSICAL PACKET

- Fill out ALL parts of the Annual Physical Packet.

• Cover page	• Concussion & Head Injury Fact Sheet sign off
• Athletic Participation Form	• Random Steroid Testing Consent Form
• Preparation Physical Evaluation History Form	• Opioid Video sign off sheet
• Health History Update Questionnaire	• Sudden Cardiac Death Pamphlet sign off
• Random Drug Testing Consent Form	

- Bring this packet with you to your physical to be completed by your physician.
- Completed ATHLETICS PHYSICAL PACKET must be turned into the school nurse.

Step 2 Read Only (DO NOT PRINT THESE FORMS)

- forms can be found at https://shorturl.at/mFJN0

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

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

PARENT/GUARDIAN/STUDENT CONSENTS

_____ has my permission to participate in all interscholastic sports checked below (Name of Athlete)

FALL	WINTER	SPRING
____ Football	____ Basketball (G)(B)	____ Baseball
____ Cheerleading	____ Wrestling (G)(B)	____ Softball
____ Marching Band	____ Competition Cheer	____ Track (G) (B)
____ Soccer (G)(B)	____ Ice Hockey	____ Tennis (B)
____ Tennis (G)		
____ Cross Country (G)(B)		

Parent Signature: _____ **Date:**_____

Student Signature: _____ **Date:**_____

ESCUELA SECUNDARIA HOPATCONG
DEPARTAMENTO DE ATLÉTICO

PAQUETE FÍSICO ANUAL

Todos los estudiantes que deseen participar en atletismo en Hopatcong High School deben completar todas las partes del proceso de inscripción.

Paso 1 PAQUETE FÍSICO DE ATLETISMO Hopatcong

- Complete TODAS las partes del Paquete Físico Anual.

• Portada	• Aprobación de la hoja informativa sobre conmociones cerebrales y lesiones en la cabeza
• Formulario de participación atlética	• Formulario de consentimiento para pruebas aleatorias de esteroides
• Preparación Formulario de Historial de Evaluación Física	• Hoja de aprobación de vídeo sobre opioides
• Cuestionario de actualización del historial médico	• Aprobación del folleto sobre muerte súbita cardíaca
• Formulario de consentimiento para pruebas de drogas aleatorias	

- Lleve este paquete a su examen físico para que lo complete su médico.
- El PAQUETE FÍSICO DE DEPORTES completado debe entregarse a la enfermera de la escuela.

Paso 2 Sólo lectura (NO IMPRIMIR ESTOS FORMULARIOS)

- los formularios se pueden encontrar en https://shorturl.at/mFJN0

• Política de conmoción cerebral de NJSIAA	• Política de pruebas de esteroides de la NJSIAA
• Política de conmoción cerebral de Hopatcong BOE	• Información sobre muerte súbita cardíaca en atletas jóvenes
• Protocolo de conmoción cerebral del HHS	• Información sobre lesiones oculares relacionadas con los deportes
• Política de pruebas aleatorias de drogas de Hopatcong BOE	• Información y vídeo sobre el uso y uso indebido de opioides

Al firmar a continuación, reconozco que he completado, leído y comprendido toda la información indicada en los Pasos 1 y 2 anteriores.

CONSENTIMIENTOS DEL PADRE/TUTOR/ESTUDIANTE

_____ tiene mi permiso para participar en todos los deportes interescolares marcados a continuación (Nombre del atleta)

CAER	INVIERNO	PRIMAVERA
____ Fútbol americano	____ Baloncesto (G)(B)	____ Béisbol
____ Animadoras	____ Lucha libre (G)(B)	____ Softbol
____ Banda de marcha	____ Aplausos de competencia	____ Pista (G) (B)
____ Fútbol (G)(B)	____ Hockey sobre hielo	____ Tenis (B)
____ Tenis (G)		
____ Campo a través (G)(B)		

Firma de los padres: _____ **Fecha:**_____

Firma del estudiante: _____ **Fecha:**_____

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

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student-Athlete Cardiac Assessment Professional Development module hosted by the New Jersey Department of Education.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU *(CONTINUED)*	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The Medical Eligibility Form is the only form that should be submitted to a school.

PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name:_____ Date of birth: _____

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or 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 as having 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 whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (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 questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student - Athlete Cardiac Assessment Professional Development module Hosted by the New Jersey Department of Education.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

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, e-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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) _____		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

Preparticipation Physical Evaluation Medical Eligibility Form

The Medical Eligibility Form is the only form that should be submitted to school. It should be kept on file with the student's school health record.

Student Athlete's Name _____ Date of Birth _____

Date of Exam _____

- o Medically eligible for all sports without restriction
- o Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of
- o Medically eligible for certain sports
- o Not medically eligible pending further evaluation
- o Not medically eligible for any sports

Recommendations: _____

I have reviewed the history form and examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings- are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Signature of physician, APN, PA _____ Office stamp (optional)

Address: _____

Name of healthcare professional (print) _____

I certify I have completed the Cardiac Assessment Professional Development Module developed by the New Jersey Department of Education.

Signature of healthcare provider _____

Shared Health Information

Allergies _____

Medications:

Other information: _____

Emergency Contacts: _____

**This form has been modified to meet the statutes set forth by New Jersey.*

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 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: _____

Sports-Related Concussion and Head Injury Fact Sheet and Parent/Guardian Acknowledgement Form

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 fogginess
- 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:

- CDC Heads Up
- Keeping Heads Healthy
- National Federation of State High School Associations
- Athletic Trainers' Society of New Jersey

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

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

Hoja informativa sobre la conmoción cerebral relacionada con el deporte y lesiones en la cabeza y el formulario de reconocimiento de padres/tutores

Una conmoción cerebral es una lesión cerebral que puede ser causada por un golpe en la cabeza o el cuerpo que interrumpe el funcionamiento normal del cerebro. Las conmociones cerebrales son un tipo de lesión cerebral traumática (TBI), que puede variar de leve a grave y puede alterar la forma en que el cerebro normalmente funciona. Las conmociones cerebrales pueden causar deterioro neuropsicológico significativo y sostenido que afecta la resolución de problemas, planificación, memoria, atención, concentración y comportamiento.

Los Centros para el Control y la Prevención de Enfermedades estiman que 300.000 conmociones cerebrales se mantienen durante las actividades relacionadas con el deporte en todo el país, y más de 62.000 conmociones cerebrales se mantienen cada año en los deportes de contacto de la escuela secundaria. El síndrome de segundo impacto ocurre cuando una persona sufre una segunda conmoción cerebral mientras sigue experimentando síntomas de una conmoción cerebral previa. Puede conducir a un deterioro grave e incluso a la muerte de la víctima.

La legislación (P.L.2010, Capítulo 94) firmada el 7 de diciembre de 2010, ordenaba que se tomaran medidas para garantizar la seguridad de los estudiantes-atletas K-12 involucrados en deportes interescolares en Nueva Jersey. Es imperativo que los atletas, entrenadores y padres / tutores estén informados sobre la naturaleza y el tratamiento de las conmociones cerebrales relacionadas con el deporte y otras lesiones en la cabeza. La legislación establece que:

- Todos los entrenadores, entrenadores atléticos, enfermeras escolares y médicos de la escuela / equipo deberán completar un Programa de Entrenamiento de Seguridad Interescolar de Lesiones en la Cabeza para el año escolar 2011-2012.
- Todos los distritos escolares, escuelas autónomas y escuelas no públicas que participan en deportes interescolares distribuirán anualmente este hecho educativo a todos los estudiantes atletas y obtendrán un reconocimiento firmado por cada padre / tutor y estudiante atleta.
- Cada distrito escolar, escuela autónoma y escuela privada deberá desarrollar una política escrita que describa la prevención y el tratamiento de la conmoción cerebral relacionada con los deportes y otras lesiones en la cabeza sufridas por estudiantes-atletas interescolares.
- Cualquier estudiante-atleta que participe en un programa deportivo interescolar y se sospeche que sufre una conmoción cerebral será retirado inmediatamente de la competencia o la práctica. El estudiante-atleta no podrá regresar a la competencia o a la práctica hasta que haya escrito la autorización de un médico capacitado en tratamiento de conmoción cerebral y haya completado el protocolo de regreso al juego graduado de su distrito.

Datos Básicos

- La mayoría de las conmociones cerebrales no implican pérdida del conocimiento.
- Puede sufrir una conmoción cerebral incluso si no se golpea la cabeza
- Un golpe en otra parte del cuerpo puede transmitir una fuerza "impulsiva" al cerebro y causar una conmoción cerebral.

Señales de conmoción cerebral (observadas por el entrenador, el preparador físico, los padres / tutores)

- Aparece aturdido/a
- Olvida jugadas o demuestra dificultades de memoria a corto plazo (por ejemplo, no está seguro del juego, oponente)

- Muestra dificultades con el equilibrio, la coordinación, la concentración y la atención.
- Responde preguntas de forma lenta o imprecisa
- Demuestra cambios de comportamiento o personalidad.
- No puede recordar eventos antes o después del golpe o la caída.

Síntomas de conmoción cerebral (informados por el estudiante-atleta)

- Dolor de cabeza
- Náusea/vómito
- Problemas de equilibrio o mareos
- Visión doble o cambios en la visión
- Sensibilidad a la luz / sonido
- Sensación de lentitud o confusión
- Dificultad para concentrarse, memoria a corto plazo y / o confusión

¿Qué debe hacer un estudiante-atleta si cree que tiene una conmoción cerebral?

- **No lo escondas.** Dígale a su Entrenador Atlético, Enfermera Escolar o Padre/Tutor.
- **Repórtalo.** No regrese a la competencia ni a la práctica con síntomas de conmoción cerebral o lesión en la cabeza. Cuanto antes lo informe, antes podrá volver a jugar.
- **Tómese tiempo para recuperarse.** Si tienes una conmoción cerebral, tu cerebro necesita tiempo para sanar. Mientras tu cerebro está sanando, es mucho más probable que sostengas una segunda conmoción cerebral. Las conmociones cerebrales repetidas pueden causar lesiones cerebrales permanentes.

¿Qué puede pasar si un estudiante-atleta continúa jugando con una conmoción cerebral o vuelve jugar muy pronto?

- Continuar jugando con los signos y síntomas de una conmoción cerebral deja al estudiante-atleta vulnerable al síndrome del segundo impacto.
- El síndrome del segundo impacto ocurre cuando un estudiante-atleta sufre una segunda conmoción cerebral mientras aún tiene síntomas de una conmoción cerebral anterior o una lesión en la cabeza.
- El síndrome del segundo impacto puede provocar un deterioro grave e incluso la muerte en casos extremos.

¿Deberían realizarse adaptaciones académicas temporales para los estudiantes deportistas que hayan sufrido una conmoción cerebral?

- Recuperar el descanso cognitivo es tan importante como el descanso físico. Leer, enviar mensajes de texto, probar, incluso ver películas, puede ralentizar la recuperación de un estudiante-atleta.
- Permanezca en casa después de la escuela con una estimulación mental y social mínima hasta que todos los síntomas se hayan resuelto.
- Es posible que los estudiantes necesiten tomar descansos, pasar menos horas en la escuela, recibir tiempo adicional para completar las tareas, además de que se les ofrezcan otras estrategias de instrucción y adaptaciones en el aula.

Los estudiantes-atletas que han sufrido una conmoción cerebral deben completar un regreso gradual al juego antes de que puedan reanudar la competencia o la práctica, de acuerdo con el siguiente protocolo:

- **Paso 1:** Finalización de un día completo de actividades cognitivas normales (día escolar, estudio para pruebas, observación de la práctica, interacción con compañeros) sin reemergencia de ningún signo o síntoma. Si no hay retorno de los síntomas, al día siguiente por adelantado.
- **Paso 2:** Ejercicio aeróbico ligero, que incluye caminar, nadar y andar en bicicleta estacionaria, manteniendo la intensidad por debajo del 70% de la frecuencia cardíaca máxima. Sin entrenamiento de resistencia. El objetivo de este paso es aumentar la frecuencia cardíaca.

- **Paso 3:** Ejercicio específico para un deporte que incluye patinar y / o correr: sin actividades de impacto en la cabeza. El objetivo de este paso es agregar movimiento.
- **Paso 4:** Simulacros de entrenamiento sin contacto (por ejemplo, ejercicios de pase). El estudiante-atleta puede iniciar un entrenamiento de resistencia.
- **Paso 5:** Después de la autorización médica (consulta entre el personal de salud de la escuela y el médico del estudiante deportista), participación en las actividades normales de entrenamiento. El objetivo de este paso es restaurar la confianza y evaluar las habilidades funcionales por parte del personal médico y de entrenadores.
- **Paso 6:** Regrese al juego que implique un esfuerzo normal o una actividad de juego.

Para obtener más información sobre las conmociones cerebrales relacionadas con los deportes y otras lesiones de la cabeza, visite:

- CDC Heads Up
- Keeping Heads Healthy
- National Federation of State High School Associations
- Athletic Trainers' Society of New Jersey

Firma del estudiante-deportista	Firma del padre / tutor en letra de imprenta	Fecha
Escriba el nombre del estudiante-atleta	Escriba el nombre del padre / tutor	Fecha

NJSIAA

1161 Route 130, P.O. Box 487, Robbinsville, NJ 08691 609-259-2776 609-259-3047-Fax

NJSIAA STEROID TESTING POLICY

CONSENT TO RANDOM TESTING

In Executive Order 72, issued December 20, 2005, Governor Richard Codey directed the New Jersey Department of Education to work in conjunction with the New Jersey State Interscholastic Athletic Association (NJSIAA) to develop and implement a program of random testing for steroids, of teams and individuals qualifying for championship games.

Beginning in the Fall, 2006 sports season, any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances on the attached page, without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition.

Athletes may submit supplements and medications to Drug Free Sport AXIS to receive information regarding banned substances or safety issues. Athletes or parents may login to the NJSIAA account at www.dfsaxis.com using the password "njsports".

The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing.

By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that, if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

Signature of Student-Athlete	Print Student-Athlete's Name	Date
Signature of Parent/Guardian	Print Parent/Guardian's Name	Date

NEW JERSEY STATE INTERSCHOLASTIC ATHLETIC ASSOCIATION

1161 Route 130 North, Robbinsville, NJ 08691

Phone 609-259-2776 ~ Fax 609-259-3047

Memorandum

To: All Athletic Directors of Member Schools

From: Tony Maselli, Assistant Director

Date: June 2019

Re: Opioid Education Video Procedure

To All Athletic Directors:

Acting to address the increased risk of opioid abuse among high school athletes, the Office of the New Jersey Coordinator for Addiction Responses and Enforcement Strategies (NJCARES) and the New Jersey State Interscholastic Athletic Association (NJSIAA) announced on February 19, 2019, a new partnership to educate student athletes and their parents/guardians on addiction risks associated with sports injuries and opioid use.

This educational initiative, spearheaded by Attorney General Gurbir Grewal and approved by the Executive Committee of the NJSIAA, is a collaborative effort to use video programming to raise awareness among high school athletes that they face a higher risk of becoming addicted to prescription pain medication than their fellow students who do not play sports.

Beginning with the 2019 fall season, we are making available to all student athletes and their parents/guardians, an educational video about the risks of opioid use as it relates to student athletes. The video will be available on August 1, 2019 and can be found on the NJSIAA website under "Athlete Wellness" which is located under the "Health & Safety" tab. We are strongly encouraging student athletes and parents/guardians to watch the video as soon as it becomes available. An acknowledgement that students and their parents/guardians have watched the video will be required starting with the 2019-2020 winter season.

All member schools are asked to add to their current athletic consent forms the sign-off listed below. The sign-off acknowledgment is an NJSIAA mandate; student athletes are required to view the video only once per school year prior to the first official practice of the season in their respective sport, but the signed acknowledgment is required for each sport a student participates in. Athletes that are 18 years or older do not need the parents/guardians to watch the video.

Opioid Video is located at (updated 12/14): https://youtu.be/_4wMz23cW_c

NJSIAA OPIOID POLICY ACKNOWLEDGEMENT

We have viewed the NJ CARES educational video on the risks of opioid use for high school athletes. We understand the NJSIAA policy that requires students, and their parents(s)/guardian(s) if a student is under the age of 18, to view this video and sign this acknowledgement.

Student's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

ASOCIACIÓN ATLÉTICA INTERESCOLAR DEL ESTADO DE NUEVA JERSEY

1161 Ruta 130 Norte, Robbinsville, Nueva Jersey 08691
Teléfono 609-259-2776 ~ Fax 609-259-3047

Memorándum

A: Todos los directores atléticos de las escuelas miembros
De: Tony Maselli, asistente de dirección
Fecha: Junio 2019
Re: Procedimiento en vídeo educativo sobre opioides

A Todos Los Directores Deportivos:

Actuando para abordar el mayor riesgo de abuso de opioides entre los atletas de secundaria, la Oficina del Coordinador de Respuestas a las Adicciones y Estrategias de Aplicación de la Ley de Nueva Jersey (NJCARES) y la Asociación Atlética Interescolar del Estado de Nueva Jersey (NJSIAA) anunciaron el 19 de Febrero de 2019, una nueva asociación para educar a los estudiantes atletas y a sus padres/tutores sobre los riesgos de adicción asociados con las lesiones deportivas y el uso de opioides.

Esta iniciativa educativa, encabezada por el Fiscal General Gurbir Grewal y aprobada por el Comité Ejecutivo de la NJSIAA, es un esfuerzo colaborativo para utilizar programación de video para crear conciencia entre los atletas de secundaria de que enfrentan un mayor riesgo de volverse adictos a los analgésicos recetados que sus compañeros de estudios que no practican deportes.

A partir de la temporada de otoño de 2019, pondremos a disposición de todos los estudiantes atletas y sus padres/tutores un video educativo sobre los riesgos del uso de opioides en relación con los estudiantes atletas. El video estará disponible el 1 de Agosto de 2019 y se puede encontrar en el sitio web de NJSIAA en "Athlete Wellness", que se encuentra en la pestaña "Health & Safety". Recomendamos encarecidamente a los estudiantes atletas y a los padres/tutores que vean el video tan pronto como esté disponible. Se requerirá un reconocimiento de que los estudiantes y sus padres/tutores han visto el video a partir de la temporada de invierno 2019-2020.

Se solicita a todas las escuelas miembros que agreguen a sus formularios de consentimiento atlético actuales la firma que se detalla a continuación. El reconocimiento de aprobación es un mandato de la NJSIAA; Los estudiantes atletas deben ver el video solo una vez por año escolar antes de la primera práctica oficial de la temporada en su deporte respectivo, pero se requiere el reconocimiento firmado para cada deporte en el que participa un estudiante. Los atletas que tienen 18 años o más no necesitan que los padres/tutores vean el video.

El vídeo sobre opioides se encuentra en(actualizado el 14/12):https://youtu.be/_4wMz23cW_c

RECONOCIMIENTO DE LA POLÍTICA DE OPIOIDES DE NJSIAA

Hemos visto el video educativo de NJ CARES sobre los riesgos del uso de opioides para los atletas de secundaria. Entendemos la política de NJSIAA que requiere que los estudiantes y sus padres/tutores, si un estudiante es menor de 18 años, vean este video y firmen este reconocimiento.

Firma del estudiante: _____ Fecha: _____

Firma del padre/tutor: _____ Fecha: _____

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: _____

New Jersey Department of Education 2014: pursuant to the Scholastic Student-Athlete Safety Act, P.L. 2013, c.71

E14-00195

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: _____