

BCSSSD SPORTS PHYSICAL PARENT'S CHECKLIST

NAME _____

ALL forms must be completed prior to _____ for
your child may participate in any sport.

ALL FORMS MUST BE COMPLETED IN THEIR ENTIRTY

- ☐ Pre-participation History Form by Parent
- ☐ Physical Examination Form by Doctor
- ☐ Clearance Form by Doctor
- ☐ Received Sudden Cardiac Death Pamphlet
- ☐ Sudden Cardiac Death Pamphlet signed by Parent and
Student Athlete
- ☐ Signed Release of Medical Information
- ☐ Received Concussion Fact Sheet
- ☐ Signed Concussion Pamphlet
- ☐ Received Opioid Fact Sheet
- ☐ Signed Opioid Fact Signed
- ☐ Special Olympics physical (if applicable)

■ 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 _____

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

■ 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* <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)*			
Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis 			
Neurologic*			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional <ul style="list-style-type: none"> Duck-walk, single leg hop 			

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
 *Consider GU exam if in private setting. Having third party present is recommended.
 *Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- ☐ Not cleared
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____
- Reason _____

Recommendations _____

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

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

Address _____ Phone _____

Signature of physician, APN, PA _____

■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

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

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports _____

Reason _____

Recommendations _____

EMERGENCY INFORMATION

Allergies _____

Other information _____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____

(Date)

Approved _____ Not Approved _____

Signature: _____

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

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

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

BURLINGTON COUNTY SPECIAL SERVICES SCHOOL DISTRICT

Sudden Cardiac Death Pamphlet Sign Off Sheet

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: _____

BURLINGTON COUNTY SPECIAL SERVICES SCHOOL DISTRICT

Permission for Release of Medical Information

I/We hereby give BCSSSD permission to share my son/daughter's Sports Physicals with other school districts, team coaches, band, and any pertinent sports bodies or any school sponsored events that require physicals .

Parent/ Guardian: _____

Student's Name: _____

Date: _____



OPIOID USE AND MISUSE EDUCATIONAL FACT SHEET

Keeping Student-Athletes Safe

School athletics can serve an integral role in students' development. In addition to providing healthy forms of exercise, school athletics foster friendships and camaraderie, promote sportsmanship and fair play, and instill the value of competition.

Unfortunately, sports activities may also lead to injury and, in rare cases, result in pain that is severe or long-lasting enough to require a prescription opioid painkiller.¹ It is important to understand that overdoses from opioids are on the rise and are killing Americans of all ages and backgrounds. Families and communities across the country are coping with the health, emotional and economic effects of this epidemic.²

This educational fact sheet, created by the New Jersey Department of Education as required by state law (*N.J.S.A. 18A:40-41.10*), provides information concerning the use and misuse of opioid drugs in the event that a health care provider prescribes a student-athlete or cheerleader an opioid for a sports-related injury. Student-athletes and cheerleaders participating in an interscholastic sports program (and their parent or guardian, if the student is under age 18) must provide their school district written acknowledgment of their receipt of this fact sheet.

How Do Athletes Obtain Opioids?

In some cases, student-athletes are prescribed these medications. According to research, about a third of young people studied obtained pills from their own previous prescriptions (i.e., an unfinished prescription used outside of a physician's supervision), and 83 percent of adolescents had unsupervised access to their prescription medications.³ It is important for parents to understand the possible hazard of having unsecured prescription medications in their households. Parents should also understand the importance of proper storage and disposal of medications, even if they believe their child would not engage in non-medical use or diversion of prescription medications.

What Are Signs of Opioid Use?

According to the National Council on Alcoholism and Drug Dependence, 12 percent of male athletes and 8 percent of female athletes had used prescription opioids in the 12-month period studied.³ In the early stages of abuse, the athlete may exhibit unprovoked nausea and/or vomiting. However, as he or she develops a tolerance to the drug, those signs will diminish. Constipation is not uncommon, but may not be reported. One of the most significant indications of a possible opioid addiction is an athlete's decrease in academic or athletic performance, or a lack of interest in his or her sport. If these warning signs are noticed, best practices call for the student to be referred to the appropriate professional for screening,⁴ such as provided through an evidence-based practice to identify problematic use, abuse and dependence on illicit drugs (e.g., Screening, Brief Intervention, and Referral to Treatment (SBIRT)) offered through the New Jersey Department of Health.

What Are Some Ways Opioid Use and Misuse Can Be Prevented?

According to the New Jersey State Interscholastic Athletic Association (NJSIAA) Sports Medical Advisory Committee chair, John P. Kripsak, D.O., "Studies indicate that about 80 percent of heroin users started out by abusing narcotic painkillers."

The Sports Medical Advisory Committee, which includes representatives of NJSIAA member schools as well as experts in the field of healthcare and medicine, recommends the following:

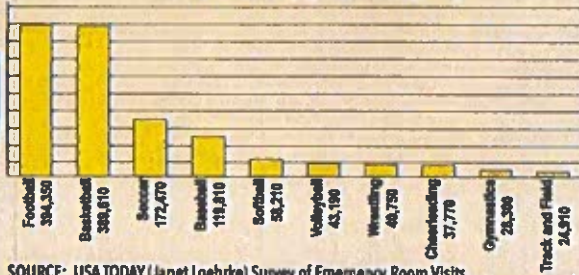
- The pain from most sports-related injuries can be managed with non-narcotic medications such as acetaminophen, non-steroidal anti-inflammatory medications like ibuprofen, naproxen or aspirin. Read the label carefully and always take the recommended dose, or follow your doctor's instructions. More is not necessarily better when taking an over-the-counter (OTC) pain medication, and it can lead to dangerous side effects.⁴
- Ice therapy can be utilized appropriately as an anesthetic.
- Always discuss with your physician exactly what is being prescribed for pain and request to avoid narcotics.
- Tramadol, a non-opioid analgesic in the serotonin uptake inhibitor category, is a good choice should the previously listed options be insufficient to relieve pain.
- In extreme cases, such as severe trauma or post-surgical pain, opioid pain medication should not be prescribed for more than five days at a time;
- Parents or guardians should always control the dispensing of pain medications and keep them in a safe, non-accessible location; and
- Unused medications should be disposed of immediately upon cessation of use. Ask your pharmacist about drop-off locations or home disposal kits like Deterra or Medsaway.

According to NJSIAA Sports Medical Advisory Committee chair, John P. Kripsak, D.O., "Studies indicate that about 80 percent of heroin users started out by abusing narcotic painkillers."



Number of Injuries Nationally in 2012 Among Athletes 19 and Under from 10 Popular Sports

(Based on data from U.S. Consumer Product Safety Commission's National Electronic Injury Surveillance System)



SOURCE: USA TODAY (Janet Loehrke) Survey of Emergency Room Visits

Even With Proper Training and Prevention, Sports Injuries May Occur

There are two kinds of sports injuries. Acute injuries happen suddenly, such as a sprained ankle or strained back. Chronic injuries may happen after someone plays a sport or exercises over a long period of time, even when applying overuse-preventative techniques.⁵

Athletes should be encouraged to speak up about injuries, coaches should be supported in injury-prevention decisions, and parents and young athletes are encouraged to become better educated about sports safety.⁶

What Are Some Ways to Reduce the Risk of Injury?

Half of all sports medicine injuries in children and teens are from overuse. An overuse injury is damage to a bone, muscle, ligament, or tendon caused by repetitive stress without allowing time for the body to heal. Children and teens are at increased risk for overuse injuries because growing bones are less resilient to stress. Also, young athletes may not know that certain symptoms are signs of overuse.

The best way to deal with sports injuries is to keep them from happening in the first place. Here are some recommendations to consider:



PREPARE Obtain the preparticipation physical evaluation prior to participation on a school-sponsored interscholastic or intramural athletic team or squad.



CONDITIONING Maintain a good fitness level during the season and offseason. Also important are proper warm-up and cooldown exercises.



PLAY SMART Try a variety of sports and consider specializing in one sport before late adolescence to help avoid overuse injuries.



ADEQUATE HYDRATION Keep the body hydrated to help the heart more easily pump blood to muscles, which helps muscles work efficiently.



TRAINING Increase weekly training time, mileage or repetitions no more than 10 percent per week. For example, if running 10 miles one week, increase to 11 miles the following week. Athletes should also cross-train and perform sport-specific drills in different ways, such as running in a swimming pool instead of only running on the road.



REST UP Take at least one day off per week from organized activity to recover physically and mentally. Athletes should take a combined three months off per year from a specific sport (may be divided throughout the year in one-month increments). Athletes may remain physically active during rest periods through alternative low-stress activities such as stretching, yoga or walking.



PROPER EQUIPMENT Wear appropriate and properly fitted protective equipment such as pads (neck, shoulder, elbow, chest, knee, and shin), helmets, mouthpieces, face guards, protective cups, and eyewear. Do not assume that protective gear will prevent all injuries while performing more dangerous or risky activities.

Resources for Parents and Students on Preventing Substance Misuse and Abuse

The following list provides some examples of resources:

National Council on Alcoholism and Drug Dependence - NJ promotes addiction treatment and recovery.

New Jersey Department of Human Services, Division of Mental Health and Addiction Services has a mission to decrease the abuse of alcohol, tobacco and other drugs by supporting the development of a comprehensive network of prevention, intervention and treatment services in New Jersey.

New Jersey Prevention Network includes a parent's quiz on the effects of opioids.

Operation Prevention Parent Toolkit is designed to help parents learn more about the opioid epidemic, recognize warning signs, and open lines of communication with their children and those in the community.

Parent to Parent NJ is a grassroots coalition for families and children struggling with alcohol and drug addiction.

Partnership for a Drug Free New Jersey is New Jersey's anti-drug alliance created to localize and strengthen drug-prevention media efforts to prevent unlawful drug use, especially among young people.

ReachNJ provides information for parents and families, including addiction and treatment stories.

The Science of Addiction: The Stories of Teens shares common misconceptions about opioids through the voices of teens.

Youth IMPACTING NJ is made up of youth representatives from coalitions across the state of New Jersey who have been impacting their communities and peers by spreading the word about the dangers of underage drinking, marijuana use, and other substance misuse.

- References**
- ¹ Massachusetts Technical Assistance Partnership for Prevention
 - ² Centers for Disease Control and Prevention
 - ³ New Jersey State Interscholastic Athletic

- Association (NJSIAA) Sports Medical Advisory Committee (SMAC)
- ⁴ Athletic Management, David Csillan, athletic trainer, Ewing High School, NJSIAA SMAC

- ⁵ National Institute of Arthritis and Musculoskeletal and Skin Diseases
- ⁶ USA TODAY
- ⁷ American Academy of Pediatrics

An online version of this fact sheet developed in January 2018 is available on the New Jersey Department of Education's Alcohol, Tobacco, and Other Drug Use webpage.

Website Resources

- Sudden Death in Athletes at:
www.suddeninathletes.org
- Hypertrophic Cardiomyopathy Association
www.hcm.org
- American Heart Association
www.heart.org

Collaborating Agencies:

American Academy of Pediatrics
New Jersey Chapter
3838 Quarterbridge Road, Suite 108
Hamilton, NJ 08619
(p) 609-842-0014
(f) 609-842-0015
www.aap.org

American Heart Association
1 Union Street, Suite 301
Robbinsville, NJ, 08681
(p) 609-208-0020
www.heart.org

New Jersey Department of Education
PO Box 500
Trenton, NJ 08625-0500
(p) 609-292-4488
www.state.nj.us/education

New Jersey Department of Health
and Senior Services
P. O. Box 360
Trenton, NJ 08625-0360
(p) 609-292-7837
www.state.nj.us/health

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Final editing: Stephen G. Rice, MD, PhD - January 2011



Sudden Cardiac Death in Young Athletes



The Basic Facts on Sudden Cardiac Death in Young Athletes



American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

New Jersey Chapter



Learn and Live

SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

Sudden death in young athletes between the ages of 10 and 19 is very rare. What, if anything, can be done to prevent this kind of tragedy?

What is sudden cardiac death in the young athlete?

Sudden cardiac death is the result of an unexpected failure of proper heart function, usually (about 60% of the time) during or immediately after exercise *without trauma*. Since the heart stops pumping adequately, the athlete quickly collapses, loses consciousness, and ultimately dies unless normal heart rhythm is restored using an automated external defibrillator (AED).

How common is sudden death in young athletes?

Sudden cardiac death in young athletes is very rare. About 100 such deaths are reported in the United States per year. The chance of sudden death occurring to any individual high school athlete is about one in 200,000 per year.

Sudden cardiac death is more common: in males than in females; in football and basketball than in other sports; and in African-Americans than in other races and ethnic groups.

What are the most common causes?

Research suggests that the main cause is a loss of proper heart rhythm, causing the heart to quiver instead of pumping

blood to the brain and body. This is called *ventricular fibrillation* (*ven-TRICK-you-lar fib-roo-LAY-shun*). The problem is usually caused by one of several cardiovascular abnormalities and electrical diseases of the heart that go unnoticed in healthy-appearing athletes.

The most common cause of sudden death in an athlete is *hypertrophic cardiomyopathy* (*hi-per-TRO-fic CAR-dee-oh-my-OP-a-thee*) also called HCM. HCM is a disease of the heart, with abnormal thickening of the heart muscle, which can cause serious heart rhythm problems and blockages to blood flow. This genetic disease runs in families and usually develops gradually over many years.

The second most likely cause is *congenital* (*con-JEN-it-af*) (i.e., present from birth) *abnormalities of the coronary arteries*. This means that these blood vessels are connected to the main blood vessel of the heart in an abnormal way. This differs from blockages that may occur when people get older (commonly called "coronary artery disease," which may lead to a heart attack).

Other diseases of the heart that can lead to sudden death in young people include:

- *Myocarditis* (*my-oh-car-DIE-tis*), an acute inflammation of the heart muscle (usually due to a virus).

- **Dilated cardiomyopathy**, an enlargement of the heart for unknown reasons.

- **Long QT syndrome** and other electrical abnormalities of the heart which cause abnormal fast heart rhythms that can also run in families.



- **Marfan syndrome**, an inherited disorder that affects heart valves,

walls of major arteries, eyes and the skeleton. It is generally seen in unusually tall athletes, especially if being tall is not common in other family members.

Are there warning signs to watch for?

In more than a third of these sudden cardiac deaths, there were warning signs that were not reported or taken seriously. Warning signs are:

- Fainting, a seizure or convulsions during physical activity
- Fainting or a seizure from emotional excitement, emotional distress or being startled
- Dizziness or lightheadedness, especially during exertion
- Chest pains, at rest or during exertion

- Palpitations - awareness of the heart beating unusually (skipping, irregular or extra beats) during athletics or during cool down periods after athletic participation

- Fatigue or tiring more quickly than peers

- Being unable to keep up with friends due to shortness of breath

What are the current recommendations for screening young athletes?

New Jersey requires all school athletes to be examined by their primary care physician ("medical home") or school physician at least once per year. The New Jersey Department of Education requires use of the Specific Annual Athletic Pre-Participation Physical Examination Form.

This process begins with the parents and student-athletes answering questions about *symptoms* during exercise (such as chest pain, dizziness, fainting, palpitations or shortness of breath); and questions about *family health history*.

The primary healthcare provider needs to know if any family member

died suddenly during physical activity or during a seizure. They also need to know if anyone in the family under the age of 50 had an unexplained sudden death such as drowning or car accidents. This information must be provided annually for



each exam because it is so *essential* to identify those at risk for sudden cardiac death.

The required physical exam includes a measurement of blood pressure and a careful listening ex-

amination of the heart, especially for murmurs and rhythm abnormalities. If there are no warning signs reported on the health history and no abnormalities discovered on exam, no further evaluation or testing is recommended.



When should a student athlete see a heart specialist?

If the primary healthcare provider or school physician has concerns, a referral to a child heart specialist, a pediatric cardiologist, is recommended. This specialist will perform a more thorough evaluation, including an electrocardiogram (ECG), which is a graph of the electrical activity of the heart. An echocardiogram, which is an ultrasound test to allow for direct visualization of the heart structure, will likely also be done. The specialist may also order a treadmill exercise test and a monitor to enable a longer recording of the heart rhythm. None of the testing is invasive or uncomfortable.

Can sudden cardiac death be prevented just through proper screening?

A proper evaluation should find most, but not all, conditions that would cause sudden death in the athlete. This is because some diseases are difficult to uncover and may only develop later in life. Others can develop following a normal screening evaluation, such as an infection of the heart muscle from a virus.

This is why screening evaluations and a review of the family health history need to be performed on a yearly basis by the athlete's primary healthcare provider. With proper screening and evaluation, most cases can be identified and prevented.

Why have an AED on site during sporting events?

The only effective treatment for ventricular fibrillation is immediate use of an automated external defibrillator (AED). An AED can restore the heart back into a normal rhythm. An AED is also life-saving for ventricular fibrillation caused by a blow to the chest over the heart (commotio cordis).

The American Academy of Pediatrics/New Jersey Chapter recommends that schools:

- Have an AED available at every sports event (three minutes total time to reach and return with the AED)
- Have personnel available who are trained in AED use present at practices and games.
- Have coaches and athletic trainers trained in basic life support techniques (CPR)
- Call 911 immediately while someone is retrieving the AED.

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 | • Sensitivity to light/sound |
| • Nausea/vomiting | • Feeling of sluggishness or fogginess |
| • Balance problems or dizziness | • Difficulty with concentration, short term memory, and/or confusion |
| • Double vision or changes in vision | |

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 too 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:

www.cdc.gov/concussion/sports/index.html

www.nfhs.com

www.ncaa.org/health-safety

www.bianj.org

www.atsnj.org

Signature of Student-Athlete

Print Student-Athlete's Name

Date

Signature of Parent/Guardian

Print Parent/Guardian's Name

Date



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 appropriate school personnel as determined by your district prior to the first official practice session of the spring 2018 athletic season (March 2, 2018, as determined by the New Jersey State Interscholastic Athletic Association) and annually thereafter prior to the student-athlete's or cheerleader's first official practice of the school year.

Name of School: _____

Name of School District (if applicable): Burlington County Special Services

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

Student Signature: _____

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

Date: _____

Does not include athletic clubs or intramural events.



**Special
Olympics**
New Jersey

PARTICIPATION PACKET REQUIRED ITEMS CHECKLIST



**Special
Olympics**
New Jersey

PLEASE NOTE: All required boxes must be checked on this checklist in order for an athlete to be cleared for participation.

PAGE 1: Release Form

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Athlete name | <input type="checkbox"/> Athlete signature (IF OWN GUARDIAN) |
| <input type="checkbox"/> Date | <input type="checkbox"/> Parent/guardian signature (IF ATHLETE NOT OWN GUARDIAN) |

PAGE 2: Emergency Medical Care Refusal Form (Athlete Completion) **OR** PAGE 3: Emergency Medical Care Refusal Form (Parent/Guardian Completion)

- ☐ *Required **ONLY IF** the athlete or the parent/guardian of the athlete checks either box in item 4 on the Release Form.

PAGE 4: Athlete Medical Form - Health History (Completed by athlete or parent/guardian/caregiver)

- | | |
|--|----------------------------------|
| <input type="checkbox"/> Athlete first and last name | <input type="checkbox"/> Address |
| <input type="checkbox"/> Date of birth | <input type="checkbox"/> Gender |

PAGE 5: Athlete Medical Form - Health History (Completed by athlete or parent/guardian/caregiver)

- | | |
|--|--|
| <input type="checkbox"/> Diagnosed with any listed conditions OR list of current medications | <input type="checkbox"/> Relationship to athlete of person completing form |
| <input type="checkbox"/> Name of person completing form | <input type="checkbox"/> Phone OR email of person completing form |

PAGE 6: Athlete Medical Form - Physical Exam (Completed by a medical professional **ONLY**)

- | | |
|--|---|
| <input type="checkbox"/> Examiner has entered ANY medical physical information | <input type="checkbox"/> Date of exam |
| <input type="checkbox"/> Examiner clears athlete for participation | <input type="checkbox"/> Recommendations* |
| | <input type="checkbox"/> Examiner signature/stamp |
| | <input type="checkbox"/> Phone, email, AND/OR license # |

PAGE 7: Athlete Medical Form - Medical Referral Form (Completed by a medical professional **ONLY**)

- ☐ * Required **ONLY IF** the athlete is not cleared as per the recommendations section on the Athlete Medical Form - Physical Exam page.

Please make a copy of each page to keep for yourself before submission. Please submit the original copy.
Thank you for your interest in Special Olympics New Jersey!

RELEASE FORM

Special Olympics
New Jersey



I want to take part in Special Olympics and agree to the following:

1. **Able to Participate.** I am able to take part in Special Olympics. I know there is a risk of injury.
2. **Photo Release.** Special Olympics organizations may use my picture, video, name, voice, and words to promote Special Olympics.
3. **Overnight Stay.** For some events, I may stay in a hotel or someone's home. If I have questions, I will ask.
4. **Emergency Care.** If I am unable, or my guardian is unavailable, to make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I check one of these boxes:
 - ☐ I have a religious or other objection to receiving medical treatment.
 - ☐ I do not consent to blood transfusions.

(If either box is checked, an **EMERGENCY MEDICAL CARE REFUSAL FORM** must be completed.)
5. **Health Programs.** If I take part in a health program, I consent to health activities, exams, and treatment. This should not replace regular health care. I can say no to treatment or anything else any time.
6. **Personal Information.** I understand my information may be used and shared by Special Olympics to:
 - Make sure I am eligible and can participate safely;
 - Run trainings and events and share results;
 - Put my information in a computer system;
 - Provide health treatment, make referrals, consult doctors, and remind me about follow-up services;
 - Research, share, and respond to needs of Special Olympics athletes (identifying information removed if shared publicly); and
 - Protect health and safety, respond to government requests, and report information required by law.I can ask to see and change my information.
7. **Concussions.** I understand the risk of concussions and continuing to play sports with a concussion. I may have to get medical care if I have a suspected concussion. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

ATHLETE NAME: _____

ATHLETE SIGNATURE (required for athlete over 18 years old with capacity to sign legal documents)

I have read and understand this release. If I have questions, I will ask. By signing, I agree to this form.

Athlete Signature: _____ Date: _____

PARENT/GUARDIAN SIGNATURE (required for athlete under 18 years old or lacking capacity to sign legal documents)

I am a parent or guardian of the Athlete. I have read and understand this form and have explained the contents to the Athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the Athlete.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

EMERGENCY MEDICAL CARE REFUSAL FORM

Special Olympics
New Jersey



ATHLETE COMPLETION

(To be completed by athlete signing on own behalf)

If an athlete is not his/her own guardian, please complete Page 3 instead.

Instructions: Only complete this form if you **do not consent to emergency medical care** on religious or other grounds and have checked a box under the Emergency Care provision on the Release Form.

I, _____, am a Special Olympics Athlete with capacity to sign documents on my own behalf and agree to the following:

1. **No Consent to Emergency Medical Care.** I understand that Special Olympics' standard registration form requires athletes or their parents or guardians to consent to emergency medical care for the athlete if needed in an emergency. Based on religious beliefs or other reasons I am not consenting to emergency medical care.

YOU MUST CHECK THE BOX AND WRITE YOUR INITIALS NEXT TO ONE STATEMENT TO CONFIRM YOUR INTENT:

☐ **I DO NOT CONSENT TO ANY KIND OF MEDICAL TREATMENT, EVEN IN A LIFE-THREATENING EMERGENCY.** INITIALS: _____

☐ **I DO NOT CONSENT TO BLOOD TRANSFUSIONS, EVEN IN A LIFE-THREATENING EMERGENCY. I CONSENT TO ALL OTHER KINDS OF EMERGENCY MEDICAL CARE.** INITIALS: _____

2. **Printed Instructions.** I agree to carry printed instructions that describe my religious or other objections to medical treatment and how I wish Special Olympics to respond if I get sick or hurt and cannot speak for myself. I agree to carry these printed instructions with me at all times during my participation in any Special Olympics activity, including during meal times, in overnight accommodations, at training sessions and competitions, and during travel to and from Special Olympics activities.
3. **Friend or Family Accompaniment.** I understand that I must be accompanied by an adult friend or family member in order for that person can take personal responsibility for me during a medical emergency where I am unable to speak for myself.
4. **Emergency Medical Care If Athlete Is Not Accompanied.** I understand that, if I am not carrying the printed instructions or the accompanying adult is not present and actively taking personal responsibility for me during a medical emergency where I am unable to speak for myself, Special Olympics may seek emergency medical care for me as recommended by medical professionals responding to the emergency.
5. **Liability Release.** I release Special Olympics, its employees, and its volunteers from all claims that may arise out of taking or failing to take measures to provide me with emergency medical care. I am agreeing to this release because I have refused, knowingly and voluntarily, to give Special Olympics permission to take emergency measures, and I am expressly withholding consent to emergency medical care on religious or other grounds.

I have read and understand this release. By signing, I agree to this release.

Athlete Signature: _____ Date: _____

By signing, I agree to accompany the Athlete during Special Olympics activities and take personal responsibility for the Athlete during an emergency. I understand the extent to which the Athlete does not consent to emergency medical care and agree to act in accordance with the Athlete's wishes as I understand them.

Signature of Accompanying Adult: _____ Date: _____

Printed Name: _____ Relationship: _____

EMERGENCY MEDICAL CARE REFUSAL FORM

Special Olympics
New Jersey



PARENT OR GUARDIAN COMPLETION

(To be completed by parent or guardian of athlete who is under 18 years old or otherwise has a legal guardian)

Instructions: Only complete this form if you **do not consent to emergency medical care** on religious or other grounds and have checked a box under the Emergency Care provision on the Release Form.

I am the parent/guardian of _____ (the "Athlete") and agree to the following:

1. **No Consent to Emergency Medical Care.** I understand that Special Olympics' standard registration form requires athletes or their parents or guardians to consent to emergency medical care for the athlete if needed in an emergency. Based on religious beliefs or other reasons I am not consenting to emergency medical care as follows.

YOU MUST **CHECK** THE BOX AND WRITE YOUR **INITIALS** NEXT TO **ONE** STATEMENT TO CONFIRM YOUR INTENT:

☐ I DO NOT CONSENT TO ANY KIND OF MEDICAL TREATMENT, EVEN IN A LIFE-THREATENING EMERGENCY. INITIALS: _____

☐ I DO NOT CONSENT TO BLOOD TRANSFUSIONS, EVEN IN A LIFE-THREATENING EMERGENCY. I CONSENT TO ALL OTHER KINDS OF EMERGENCY MEDICAL CARE. INITIALS: _____

2. **Accompaniment of Athlete.** I understand that I must be present in order to take personal responsibility for the Athlete if any medical treatment is to be refused on the athlete's behalf in a medical emergency arises. This includes during meal times, in overnight accommodations, at training sessions and competitions, and during travel to and from Special Olympics activities.
3. **Emergency Medical Care If Athlete Is Not Accompanied.** I understand that, if I am not present and actively taking personal responsibility for the Athlete during a medical emergency, Special Olympics will seek emergency medical care for the athlete as recommended by medical professionals responding to the emergency.
4. **Liability Release.** On behalf of myself and the Athlete, I release Special Olympics, its employees, and its volunteers from all claims that may arise out of taking or failing to take measures to provide the Athlete with emergency medical care. I am agreeing to this release because I have refused, knowingly and voluntarily, to give Special Olympics permission to take emergency measures, and I am expressly withholding consent to emergency medical care on religious or other grounds.

I am authorized to enter into this Release on the Athlete's behalf. I have read and understand this release and have explained the contents to the Athlete as appropriate. By signing, I agree that this Release shall be binding upon me, the Athlete, and our respective heirs and legal representatives.

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Athlete Medical Form – HEALTH HISTORY
(to be completed by athlete or parent/guardian/caregiver)

**Special
Olympics**
New Jersey



AREA:

LOCAL TRAINING PROGRAM:

ATHLETE INFORMATION

First Name: Middle Name:

Last Name:

Date Birth (mm/dd/yyyy): Female: ☐ Male: ☐

Address (Street):

Address (City, State, Zip):

Phone: Cell:

E-mail:

Eye color: Ethnicity: (optional)

Athlete Employer, if any:

I am my own guardian. ☐ Yes ☐ No

Does the athlete have (check any that apply):

☐ Autism ☐ Down syndrome ☐ Fragile X Syndrome

☐ Cerebral Palsy ☐ Fetal Alcohol Syndrome

☐ Other syndrome, please specify:

Is the athlete allergic to any of the following (please list):

☐ Latex ☐ No Known Allergies

☐ Medications:

☐ Insect Bites or Stings:

☐ Food:

List any special dietary needs:

List all past surgeries:

Does the athlete currently have any chronic or acute infection?

☐ No ☐ Yes If yes, please describe:

Has the athlete ever had an abnormal Electrocardiogram (EKG) or Echocardiogram (Echo)? If yes, select below and describe

☐ Yes, had abnormal EKG ☐ Yes, had abnormal Echo

☐ PARENT ☐ GUARDIAN INFORMATION (if not own guardian)

Name:

Phone: Cell:

E-mail:

Emergency Contact Name: Same as Above: ☐

Emergency Contact Phone (cell):

Emergency Contact Relationship:

Does the athlete have a primary care physician? ☐ Yes ☐ No If yes, list.

Physician Name: Physician Phone:

Insurance Policy (Company and Number):

Does the athlete have any objections to emergency medical care?

☐ No ☐ Yes If yes, contact your local Program to get the Emergency Care Refusal Form.

List any sports the athlete wishes to play:

Has a doctor ever limited the athlete's participation in sports?

☐ No ☐ Yes If yes, please describe:

Does the athlete use (check any that apply):

☐ Brace ☐ Colostomy ☐ Communication Device

☐ C-PAP Machine ☐ Crutches or Walker ☐ Dentures

☐ Glasses or Contacts ☐ G-Tube or J-Tube ☐ Hearing Aid

☐ Implanted Device ☐ Inhaler ☐ Pacemaker

☐ Removable Prosthetics ☐ Splint ☐ Wheel Chair

Has the athlete had a Tetanus vaccine in the past 7 years? ☐ No ☐ Yes

FAMILY HISTORY

Has any relative died of a heart problem before age 50? ☐ No ☐ Yes

Has any family member or relative died while exercising? ☐ No ☐ Yes

List all medical conditions that run in the athlete's family:

Athlete Medical Form – HEALTH HISTORY

(to be completed by athlete or parent/guardian/caregiver)

**Special
Olympics**
New Jersey



Athlete's Name:

HAS THE ATHLETE EVER BEEN DIAGNOSED WITH OR EXPERIENCED ANY OF THE FOLLOWING CONDITIONS

Loss of Consciousness	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke/TIA	<input type="checkbox"/> No <input type="checkbox"/> Yes
Dizziness during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	Concussions	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headache during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Vision Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chest pain during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing Impairment	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Shortness of breath during or after exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes	Enlarged Spleen	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Irregular, racing or skipped heart beats	<input type="checkbox"/> No <input type="checkbox"/> Yes	Single Kidney	<input type="checkbox"/> No <input type="checkbox"/> Yes	Urinary Discomfort	<input type="checkbox"/> No <input type="checkbox"/> Yes
Congenital Heart Defect	<input type="checkbox"/> No <input type="checkbox"/> Yes	Osteoporosis	<input type="checkbox"/> No <input type="checkbox"/> Yes	Spina Bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Attack	<input type="checkbox"/> No <input type="checkbox"/> Yes	Osteopenia	<input type="checkbox"/> No <input type="checkbox"/> Yes	Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cardiomyopathy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heat Illness	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Valve Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Sickle Cell Trait	<input type="checkbox"/> No <input type="checkbox"/> Yes	Broken Bones	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes	Easy Bleeding	<input type="checkbox"/> No <input type="checkbox"/> Yes	Dislocated Joints	<input type="checkbox"/> No <input type="checkbox"/> Yes
Endocarditis	<input type="checkbox"/> No <input type="checkbox"/> Yes				

Difficulty controlling bowels or bladder

☐ No ☐ Yes

If yes, is this new or worse in the past 3 years?

☐ No ☐ Yes

Numbness or tingling in legs, arms, hands or feet

☐ No ☐ Yes

If yes, is this new or worse in the past 3 years?

☐ No ☐ Yes

Weakness in legs, arms, hands or feet

☐ No ☐ Yes

If yes, is this new or worse in the past 3 years?

☐ No ☐ Yes

Burner, stinger, pinched nerve or pain in the neck, back, shoulders, arms, hands, buttocks, legs or feet

☐ No ☐ Yes

If yes, is this new or worse in the past 3 years?

☐ No ☐ Yes

Head Tilt

☐ No ☐ Yes

If yes, is this new or worse in the past 3 years?

☐ No ☐ Yes

Spasticity

☐ No ☐ Yes

If yes, is this new or worse in the past 3 years?

☐ No ☐ Yes

Paralysis

☐ No ☐ Yes

If yes, is this new or worse in the past 3 years?

☐ No ☐ Yes

List any other ongoing or past medical conditions:

Describe any past broken bones or dislocated joints (if yes is checked for either of those fields above):

Epilepsy or any type of seizure disorder

☐ No ☐ Yes

If yes, list seizure type:

If yes, had seizure during the past year?

☐ No ☐ Yes

Self-injurious behavior during the past year

☐ No ☐ Yes

Aggressive behavior during the past year

☐ No ☐ Yes

Depression (diagnosed)

☐ No ☐ Yes

Anxiety (diagnosed)

☐ No ☐ Yes

Describe any additional mental health concerns:

PLEASE LIST ANY MEDICATION, VITAMINS OR DIETARY SUPPLEMENTS BELOW (includes inhalers, birth control or hormone therapy)

Medication, Vitamin or Supplement	Dosage	Times per Day	Medication, Vitamin or Supplement	Dosage	Times per Day	Medication, Vitamin or Supplement	Dosage	Times per Day

Is the athlete able to administer his or her own medications? ☐ No ☐ Yes

If female athlete, list date of last menstrual period:

Name of Person Completing this Form

Relationship to Athlete

Phone

Email

Athlete Medical Form – PHYSICAL EXAM

(to be completed by a Medical Professional only)

Special
Olympics
New Jersey



Athlete's Name:

MEDICAL PHYSICAL INFORMATION (TO BE COMPLETED BY EXAMINER ONLY)

Height	Weight	BMI (optional)	Temperature	Pulse	O ₂ Sat	Blood Pressure	Vision
<input type="text"/> cm	<input type="text"/> kg	<input type="text"/> BMI	<input type="text"/> C	<input type="text"/>	<input type="text"/>	BP Right: <input type="text"/>	BP Left: <input type="text"/>
<input type="text"/> in	<input type="text"/> lbs	<input type="text"/> Body Fat %	<input type="text"/> F	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Right Hearing (Finger Rub) <input type="checkbox"/> Responds <input type="checkbox"/> No Response <input type="checkbox"/> Can't Evaluate	Bowel Sounds <input type="checkbox"/> Yes <input type="checkbox"/> No
Left Hearing (Finger Rub) <input type="checkbox"/> Responds <input type="checkbox"/> No Response <input type="checkbox"/> Can't Evaluate	Hepatomegaly <input type="checkbox"/> No <input type="checkbox"/> Yes
Right Ear Canal <input type="checkbox"/> Clear <input type="checkbox"/> Cerumen <input type="checkbox"/> Foreign Body	Splenomegaly <input type="checkbox"/> No <input type="checkbox"/> Yes
Left Ear Canal <input type="checkbox"/> Clear <input type="checkbox"/> Cerumen <input type="checkbox"/> Foreign Body	Abdominal Tenderness <input type="checkbox"/> No <input type="checkbox"/> RUQ <input type="checkbox"/> RLQ <input type="checkbox"/> LUQ <input type="checkbox"/> LLQ
Right Tympanic Membrane <input type="checkbox"/> Clear <input type="checkbox"/> Perforation <input type="checkbox"/> Infection <input type="checkbox"/> NA	Kidney Tenderness <input type="checkbox"/> No <input type="checkbox"/> Right <input type="checkbox"/> Left
Left Tympanic Membrane <input type="checkbox"/> Clear <input type="checkbox"/> Perforation <input type="checkbox"/> Infection <input type="checkbox"/> NA	Right upper extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia
Oral Hygiene <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Left upper extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia
Thyroid Enlargement <input type="checkbox"/> No <input type="checkbox"/> Yes	Right lower extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia
Lymph Node Enlargement <input type="checkbox"/> No <input type="checkbox"/> Yes	Left lower extremity reflex <input type="checkbox"/> Normal <input type="checkbox"/> Diminished <input type="checkbox"/> Hyperreflexia
Heart Murmur (supine) <input type="checkbox"/> No <input type="checkbox"/> 1/6 or 2/6 <input type="checkbox"/> 3/6 or greater	Abnormal Gait <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Heart Murmur (upright) <input type="checkbox"/> No <input type="checkbox"/> 1/6 or 2/6 <input type="checkbox"/> 3/6 or greater	Spasticity <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Heart Rhythm <input type="checkbox"/> Regular <input type="checkbox"/> Irregular	Tremor <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below
Lungs <input type="checkbox"/> Clear <input type="checkbox"/> Not clear	Neck & Back Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Right Leg Edema <input type="checkbox"/> No <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+	Upper Extremity Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Left Leg Edema <input type="checkbox"/> No <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+	Lower Extremity Mobility <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Radial Pulse Symmetry <input type="checkbox"/> Yes <input type="checkbox"/> R>L <input type="checkbox"/> L>R	Upper Extremity Strength <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Cyanosis <input type="checkbox"/> No <input type="checkbox"/> Yes, describe	Lower Extremity Strength <input type="checkbox"/> Full <input type="checkbox"/> Not full, describe below
Clubbing <input type="checkbox"/> No <input type="checkbox"/> Yes, describe	Loss of Sensitivity <input type="checkbox"/> No <input type="checkbox"/> Yes, describe below

ATLANTO-AXIAL INSTABILITY (AAI)

- ☐ Athlete shows **NO EVIDENCE** of neurological symptoms or physical findings associated with spinal cord compression or atlantoaxial instability.
- ☐ Athlete has neurological symptoms or physical findings that could be associated with spinal cord compression or atlantoaxial instability and **must** receive an additional neurological evaluation to rule out additional risk of spinal cord injury prior to clearance for sports participation.

RECOMMENDATIONS (TO BE COMPLETED BY EXAMINER ONLY)

Licensed Medical Examiners: It is recommended that the examiner review items on the medical history with the athlete or their guardian, prior to performing the physical exam. If an athlete needs further medical evaluation please use the Special Olympics Further Medical Evaluation Form, page 4, to provide the athlete with medical clearance..

- ☐ This athlete is **ABLE** to participate in Special Olympics sports without restrictions/limitations
- ☐ This athlete is **ABLE** to participate in Special Olympics sports **WITH** restrictions/limitations →
- ☐ This athlete **MAY NOT participate** in Special Olympics sports at this time and **MUST** be further evaluated by a physician for the following concerns:
- | | | |
|---|---|--|
| <input type="checkbox"/> Concerning Cardiac Exam | <input type="checkbox"/> Acute Infection | <input type="checkbox"/> O ₂ Saturation Less than 90% on Room Air |
| <input type="checkbox"/> Concerning Neurological Exam | <input type="checkbox"/> Stage II Hypertension or Greater | <input type="checkbox"/> Hepatomegaly or Splenomegaly |
| <input type="checkbox"/> Other, please describe: <input type="text"/> | | |

Additional Licensed Examiner's Notes and Recommended Follow-up:

- | | | |
|---|--|---|
| <input type="checkbox"/> Follow up with a cardiologist | <input type="checkbox"/> Follow up with a neurologist | <input type="checkbox"/> Follow up with a primary care physician |
| <input type="checkbox"/> Follow up with a vision specialist | <input type="checkbox"/> Follow up with a hearing specialist | <input type="checkbox"/> Follow up with a dentist or dental hygienist |
| <input type="checkbox"/> Follow up with a podiatrist | <input type="checkbox"/> Follow up with a physical therapist | <input type="checkbox"/> Follow up with a nutritionist |
- ☐ Other/Exam Notes:

Name

E-mail

Licensed Medical Examiner's Signature

Date of Exam

Phone

License

Athlete Medical Form – MEDICAL REFERRAL FORM

(to be completed by a **Medical Professional** only if referral is needed)

**Special
Olympics**
New Jersey



Athlete's Name:

This page only needs to be completed and signed if the physician on page three does not clear the athlete and indicates follow-up is required. Athlete should bring the previously completed pages to the appointment with the specialist.

Examiner's Name:

Specialty:

I have examined this athlete for the following medical concern(s):
Please describe

In my professional opinion, this athlete **MAY** participate in Special Olympics sports (Indicate restrictions or limitations below):

☐ Yes, without restrictions

☐ Yes, but with restrictions (*list below*)

☐ No

Additional Examiner Notes/Restrictions:

Examiner E-mail:

Examiner Phone:

License:

Examiner's Signature

Date

This section to be completed by Special Olympics staff only, if applicable.

This medical exam was completed at a MedFest event?

☐ Yes

☐ No

The athlete is a Unified Partner or a Young Athlete Participant?

☐ Unified Partner

☐ Young Athlete

CONCUSSION AWARENESS AND SAFETY RECOGNITION POLICY

Objective

It is Special Olympics' intent to take steps to help ensure the health and safety of all Special Olympics participants. All Special Olympics participants should remember that safety comes first and should take reasonable steps to help minimize risks for concussion or other serious brain injuries.

Defining a Concussion

A concussion is defined by the Centers for Disease Control as a type of traumatic brain injury caused by a bump, blow, or jolt to the head as well as serial, cumulative hits to the head. Concussions can also occur from a blow to the body that causes the head and brain to move quickly back and forth—causing the brain to bounce around or twist within the skull. Although concussions are not usually life-threatening, their effects can be serious and therefore proper attention must be paid to individuals suspected of sustaining a concussion.

Suspected or Confirmed Concussion

Effective immediately, a participant who is suspected of sustaining a concussion in practice, game or competition shall be removed from practice, play or competition at that time. If a qualified medical professional is available on-site to render an evaluation, that person shall have final authority as to whether or not a concussion is suspected. If applicable, the participant's parent or guardian should be aware that the participant is suspected of sustaining a concussion.

Return to Play

A participant who has been removed from practice, play or competition due to a suspected concussion may not participate in Special Olympics sports activities until either of the following occurs (1) at least seven (7) days have passed since the participant was removed from play and a currently licensed, qualified medical professional provides written clearance for the participant to return to practice, play and competition, or (2) a currently licensed, qualified medical professional determines that the participant did not suffer a concussion and provides written clearance for the participant to return to practice, play immediately. Written clearance in either of the scenarios above shall become a permanent record.

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: <https://youtu.be/3Rz6rkwpAx8>

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: _____