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■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

IIIATABN	EAD III		
HISTORY	FORM		

Note: Complete and sign this form (with your par Name:			ppointment. ate of birth:	
Date of examination:	Sport(s):			
Sex assigned at birth (F, M, or intersex):	_ How do you identil	y your gender? (F,	M, non-binary, or anoth	ner gender):
Have you had COVID-19? (check one): □ Y	ΠN		Ø	*
Have you been immunized for COVID-19? (che	ck one): □Y □N		u had: □ One shot [□ Booster date(s)	
List past and current medical conditions.				
Have you ever had surgery? If yes, list all past su	rgical procedures			
Medicines and supplements: List all current pres	criptions, over-the-co	unter medicines, a	nd supplements (herbal	and nutritional).
Do you have any allergies? If yes, please list all	your allergies (ie, me	dicines, pollens, fo	ood, stinging insects).	
Patient Health Questionnaire Version 4 (PHQ-4)				
Over the last 2 weeks, how often have you been	2007		to the second of	
- 1		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 eith	er subscale [question	s 1 and 2, or ques	tions 3 and 4] for scree	ening purposes.)
GENERAL QUESTIONS		HEART HEALTH QU	ESTIONS ABOUT YOU	

(Ехр	IERAL QUESTIONS Ilain "Yes" answers at the end of this form. Circle stions 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?		
HEA	RT 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.		

	ART HEALTH QUESTIONS ABOUT YOU INTINUED)		Yes	No
9.	Do you get light-headed or feel shorter of breathan your friends during exercise?	ath		
10.	Have you ever had a seizure?			
HEA	RT 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?			

			-
BON	NE 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?		
MED	ICAL 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?	4	
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?		
24.	Have you ever had or do you have any problems with your eyes or vision?		

MED	DICAL QUESTIONS (CONTINUED)		Yes	No
25.	Do you worry about your weight?			
26.	Are you trying to or has anyone recommend you gain or lose weight?	led that		
27.	Are you on a special diet or do you avoid co types of foods or food groups?	ertain		
28.	Have you ever had an eating disorder?			
MEN	ISTRUAL QUESTIONS	N/A	Yes	No
29.	Have you ever had a menstrual period?			
30.	How old were you when you had your first r period?	nenstrual		,
31.	When was your most recent menstrual perio	qŝ		
20	How many periods have you had in the past	12		

ia .		
20 3		

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:	

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■ PREPARTICIPATION PHYSICAL EVALUATION

lame:	Date of birth:		
I. Type of disability:			
2. Date of disability:			
3. Classification (if available):			
4. Cause of disability (birth, disease, injury	y, or other):		
5. List the sports you are playing:			
AND THE RESERVE OF THE PARTY OF		Yes	No
6. Do you regularly use a brace, an assist	ive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assisting			\vdash
8. Do you have any rashes, pressure sore	s, or other skin problems?		\vdash
9. Do you have a hearing loss? Do you u			\vdash
10. Do you have a visual impairment?			\vdash
II. Do you use any special devices for boy	vel or bladder function?		
12. Do you have burning or discomfort wh			\vdash
13. Have you had autonomic dysreflexia?	A 6		
	a heat-related (hyperthermia) or cold-related (hypothermia) illness?		\vdash
15. Do you have muscle spasticity?			\vdash
16. Do you have frequent seizures that can	not be controlled by medication?		\vdash
xplain "Yes" answers here.	,		
*			
ease indicate whether you have ev	ver had any of the following conditions:	9	
		Yes	No
Atlantoaxial instability			
	toaxial instability		\vdash
Radiographic (x-ray) evaluation for atlant	toaxial instability		
Radiographic (x-ray) evaluation for atlant Dislocated joints (more than one)	toaxial instability		2
Radiographic (x-ray) evaluation for atlant Dislocated joints (more than one) Easy bleeding	toaxial instability		27
Radiographic (x-ray) evaluation for atlant Dislocated joints (more than one) Easy bleeding Enlarged spleen	toaxial instability		
Radiographic (x-ray) evaluation for atlant Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis	toaxial instability		
Radiographic (x-ray) evaluation for atlant Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis	toaxial instability		
Radiographic (x-ray) evaluation for atlant Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel	toaxial instability		
Radiographic (x-ray) evaluation for atlant Dislocated joints (more than one) Easy bleeding Enlarged spleen Hepatitis Osteopenia or osteoporosis Difficulty controlling bowel Difficulty controlling bladder	toaxial instability		
Radiographic (x-ray) evaluation for atlant 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	toaxial instability		
Radiographic (x-ray) evaluation for atlant 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	toaxial instability		
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Radiographic (x-ray) evaluation for atlant 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	toaxial instability		
Radiographic (x-ray) evaluation for atlant 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	toaxial instability		
Radiographic (x-ray) evaluation for atlant 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	toaxial instability		
Radiographic (x-ray) evaluation for atlant 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	toaxial instability		
Radiographic (x-ray) evaluation for atlant 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 xplain "Yes" answers here.	knowledge, my answers to the questions on this form are complete a	and correct	et.
Radiographic (x-ray) evaluation for atlant 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 cplain "Yes" answers here.	knowledge, my answers to the questions on this form are complete a	and correct	et.

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■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM Date of birth: Name: 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 **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 o 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: