Dear Parents/Guardians,

1. Bergen Catholic High School requires annual physicals for all grade levels (Freshmen, Sophomores, Juniors and Seniors), whether they participate in sports or not. The Doctor must submit a record of immunizations, as it is mandated by the State of New Jersey. The completed medical packet may be downloaded on the Bergen Catholic website, under the "Athletics Tab and then Medical Forms Tab". Please use whichever forms apply to your medical needs.

2. ATHLETICS

Every student athlete, Freshman, Sophomore, Junior, and Senior, participating in the Fall Season must submit a current physical administered by a licensed examining physician within 365 days of the official start. All Physicals must be submitted to the Nurses Office in order to be cleared for Try-Outs and Practice. Students participating in fall sports must submit a physical by June 21st, 2021. This will allow students to participate in practices.

Every student athlete must also register on FamilyID Bergen Catholic's Medical Portal. The link to FamilyID can also be found on the Bergen Catholic website, under the "Athletics Tab and then Medical Forms Tab." When registering on FamilyID please select 2021-2022 School Year to begin your registration. If your son plans to participate on one of our interscholastic athletic teams, you must complete the information found on the Athletics registration program.

Physicals for all students need to be returned, by the first week of school. Physicals, when completed, may be mailed to: Bergen Catholic High School, 1040 Oradell Avenue, Oradell, NJ 07649 Attention: School Nurses or handed in to the main office.

3. MEDICATION

If your son takes any medication in school, please take special note of the medical slip enclosed. If this slip is **NOT** filled out but your son's doctor, **NO** medication can be administered. This written authorization must be on file in the Nurse's Office at Bergen Catholic High School.

4. PHYSICALS

If your son requires a physical this year, our partner Holy Name Medical Center is offering **free** physicals provided by their physicians at HNH Fitness Center in Oradell, NJ. Please follow these steps to book your appointment.

1. Call (201) 265-1159, indicate you are a Bergen Catholic student-athlete.
2. Print out the state physical form on the Bergen Catholic website and bring to the appointment with you, having completed the family history portion.

Thank you,

Kathleen LaBarbiera, RNBC, BSN
M. Celeste Tumino, RN, BSN, CSN
School Nurses
201-634-2216-Phone
201-634-2200-Fax

Brendan McGovern, Associate Athletic Director
bmcgovern@bergencatholic.org 201-634-4130
Joe Haemmerle, Associate Athletic Director
jhaemmerle@bergencatholic.org
Ben Chianchiano, Athletic Trainer
bchianchiano@holyname.org
Michael Vankoppen, Athletic Trainer
mvankoppen@holyname.org

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam ______________________________

Name ______________________________ Date of birth ______________

Sex _____ Age _______ Grade _________ School ____________________ Sport(s) ______________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____

____

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ____________		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ____________		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

____

____

____

____

____

____

____

____

____

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

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date ____________

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HE0503

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

9-2681/0410

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

nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

PHYSICIAN REMINDERS

1. **Consider additional questions on more sensitive issues**
   - **Do you feel stressed out or under a lot of pressure?**
   - **Do you ever feel sad, hopeless, depressed, or anxious?**
   - **Do you feel safe at your home or residence?**
   - **Have you ever tried cigarettes, chewing tobacco, snuff, or dip?**
   - **During the past 30 days, did you use chewing tobacco, snuff, or dip?**
   - **Do you drink alcohol or use any other drugs?**
   - **Have you ever taken anabolic steroids or used any other performance supplement?**
   - **Have you ever taken any supplements to help you gain or lose weight or improve your performance?**
   - **Do you wear a seat belt, use a helmet, and use condoms?**
2. **Consider reviewing questions on cardiovascular symptoms (questions 5–14).**

Date of exam ______________

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

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

☐ Cleared for all sports without restriction

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

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ______________________________

Reason ______________________________

Recommendations ______________________________

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

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

Address ______________________________ Phone ______________

Signature of physician, APN, PA ______________________________

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PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Date of Examination ____________________

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 ____

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State of 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____
   If yes, name of medication(s) ______________________________

Date:______________________ **Signature of parent/guardian** ______________________________

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE'S OFFICE

E14-00284

NJS Department of Health
IMMUNIZATION RECORD

NAME OF CHILD (Last, First, MI)						Date of Birth (M/D/Y)		Sex ☐ M ☐F
VACCINE TYPE	Disease Mo./Yr.	PRIMARY SERIES 1st Dose Mo./Day/Yr.	2nd Dose Mo./Day/Yr.	3rd Dose Mo./Day/Yr.		BOOSTERS Mo./Day/Yr.	Mo./Day/Yr.	Mo./Day/Yr.
Diphtheria & Tetanus (DPT and/or TD)	☐	☐	☐	☐		☐	☐	☐
Polio-Inactivated Polio (IPV) If oral vaccine, indicate OPV								
Meningococcal								
Varicella								
Hepatitis A #1, #2								
Measles								
Mumps								
Rubella								
Contra-Indications (Kind)			Reactions (Type)					
Hepatitis B								
H.I.B								
Other								

Mantoux Tuberculin Test Date________________Result________If positive, did student have chest X-Ray?_________Result

Physician's Signature____Date of Examination______________________

Physician's Address____

NURSE ADMINISTRATION OF MEDICATION IN SCHOOL

NAME OF STUDENT________________________________ GRADE__________________

DIAGNOSIS____

MEDICATION____

DOSAGE__________________________ FREQUENCY___________________________

DIRECTIONS____

POSSIBLE SIDE EFFECTS____

I authorize the School Nurse to administer the above medication:

Signature of M.D. Date	Signature of Parent/Guardian Date
Physician's Street Address	Town & Zip Code
Telephone Number	

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

I certify that this student has asthma or another potentially life-threatening illness and is permitted to self-administer the above medication. He/she has been instructed in the proper techniques of self-administration and has demonstrated competence in this technique.

Signature of Prescribing Physician	Date
Address	Telephone Number

****

I authorize my child to self-administer the above medication. This permission includes self-administration of medication during regular school hours and at other times when my child is participating in a school-related event. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the self-administration of this medication and that I will indemnify and hold harmless the district, school, school nurses and other school employees against any claims arising from the self-administration of medication by my child.

Date____________________Parent/Guardian Signature______________________________

BOTTOM PORTION OF THIS FORM TO BE FILLED OUT ONLY IF STUDENT SELF-MEDICATES.

Bergen Catholic High School- Information for Emergency Illness/Accident- Please Complete

Student's Year:____

Student's Name:____

Parent's Name:____

Home Address:____

____

Home Phone:____

Father's Cellphone:____________________________________

Mother's Cellphone:____________________________________

(Alternate Person to be Notified)

Name:____

Home Phone:____

Cellphone:____

Doctor to be notified: __________________________________

Hospital Preference: ___________________________________

List any allergies, Physical ailments or disorders the student has:

____

____

If in an emergency treatment is required, I hereby authorize the school authorities to use their judgement in sending my son to the hospital or the doctor most accessible before I (the parent) can be reached.

Permission is hereby granted to dispense non prescriptive medications, namely non aspirin pain reliever (Tylenol, Advil), Antacid (Tums, Pepto Bismol).

Parent's Signature: ____________________________________

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 ☐
11. Has any member of the student-athlete's household been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

Date: ______________ Signature of parent/guardian: ____________________

Please Return Completed Form to the School Nurse's Office

NEW JERSEY STATE INTERSCHOLASTIC ATHLETIC ASSOCIATION
1161 Route 130 North, Robbinsville, NJ 08691-1104
Phone 609-259-2776 ~ Fax 609-259-3047

COVID-19 Questionnaire

Name of Student: ______________________________ Date: ______________

Parent/Guardian Cell: ______________________________ Sport: ______________

COVID-19 Questions:	**Please Circle One**	
Has your son/daughter 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**
Has any member of the student-athlete's household been diagnosed with Coronavirus (COVID-19)?	**YES**	**NO**

Signature of Parent/Guardian: ____

To participate in workouts during the summer recess period, the parent/guardian must complete this form. This form only needs to be completed one time. This is a recommended template for the COVID-19 Questionnaire. Districts can determine the best means (electronic or paper) and platform (Survey Monkey, Microsoft Teams, Google Docs etc.) to administer the questionnaire.