PHYSICAL EXAMINATION: CAPE MAY COUNTY TECHNICAL HIGH SCHOOL

Parent completes:

Student Name:___________________________ **Age:** ___ **Date of Birth:** ____/_____/____**Grade:** ___**Full or Share-time**

Address: _______________________ City: __________________, NJ Zip:_______ Home Phone: __________________

PHYSICIAN OR PROVIDER INFORMATION – PLEASE COMPLETE BOTH SIDES OF FORM

ALL VITALS MUST BE ENTERED OR THE FORM WILL BE RETURNED TO THE HEALTH CARE PROVIDER

DATE OF PHYSICAL EXAMINATION: ____/____/_____

Ht.:_____inches Wt:______pounds Is Ht./Wt. normal? YES NO B/P____/____ Pulse: _______

Hearing: **R**___Dbl. **L**___Dbl. **VISION:** Tested with: ☐Glasses ☐Contacts ☐Unaided **Color Vision Test**: PASS FAIL

FAR VISION **R** 20 / **L** 20/ **OU** 20/___ **NEAR VISION** **R** 20 / **L** 20 / **OU** 20/___

Allergies: ☐**Seasonal** List: ___________________________ ☐**Animals, dust, etc.**, list: ___________________________

☐**Insects (bees, etc.):** type__________________________ Life-threatening? NO **YES***

☐**Food**(s) list:________________________________Life-threatening? NO **YES***

***If "YES" life-threatening: Emergency medical orders:** ____

☐Allergic to the following medications: List____

	Normal? (Circle one)		Abnormal Findings/ Comments
Head/Neck	YES	NO	
Eyes/Sclera/Pupils	YES	NO	
Ears	YES	NO	
Nose/Mouth/Throat	YES	NO	
Heart: Murmurs/Rhythms	YES	NO	
Lungs: Auscultation/Percussion	YES	NO	
Chest Contour	YES	NO	
Skin	YES	NO	
Abdomen: Assessment (inc. liver, spleen)	YES	NO	
Tanner Stage: Testes/Onset of Menses:	YES	NO	
Hernia (if not normal /possible, please explain)	YES **Normal**	NO **(Not Normal)**	
Neck/Back/Spine: Range of Motion:	YES	NO	
Scoliosis:	YES	NO	
Upper Extremities	YES	NO	
Lower Extremities	YES	NO	
Neurological: Balance & Coordination: Romberg:	YES YES	NO NO	
Heel Walk:	YES	NO	
Tandem Walk:	YES	NO	
Nose Touch:	YES	NO	
Toe Walk:	YES	NO	

☞ **Continued on back of page**

Student Name:________________________________

CURRENT MEDICATIONS (LIST):________________________________

IMMUNIZATIONS TODAY? Circle: TD bst MMR Varicella Meningitis: Type:____________

Hepatitis B Type (specify Adult two dose series or three dose series):____________________ Other: ____________

DIAGNOSIS:________________________________ **REFERRALS MADE?**__________________________

CLEARANCES

USE OF HAZARDOUS MACHINERY, HEIGHTS and/or CLIMBING, LIFTING, WATERWAY ACTIVITIES:

- ☐ **No health condition that would require restriction for vocational shop activities or student's working papers.**
- ☐ **Restrictions for medical conditions or side effects of medications: Describe:**__________________________

PARTICIPATION LEVEL FOR HIGH SCHOOL PHYSICAL EDUCATION PROGRAM:

- ☐ **No restrictions for school physical education program**
- ☐ **Student needs adaptive physical education plan. DIAGNOSIS/REASON:**____________________________

PARTICIPATION LEVEL FOR SPORTS PROGRAM:

A. **Student MAY participate in the following: (Check all that apply.)**

- ☐ **COLLISION/CONTACT**
- ☐ **LIMITED CONTACT**
- ☐ **NON-CONTACT/STRENUOUS**
- ☐ **NON-CONTACT/NON-STRENUOUS**

SAMPLES OF CLASSIFICATION OF SPORT BY CONTACT

Collision/Contact	Limited Contact	Non-contact/ Strenuous	Non-contact/ Non-strenuous
Field Hockey	Baseball	Discus /Javelin/Shotput	Bowling
Football	Basketball	Rowing	Golf
Ice Hockey	Cheerleading	Running/Cross	
Lacrosse	Diving	Training	
Soccer	Fencing	Swimming	
Wrestling	Field:	Tennis	
	High jump	Track	
	Pole vault		
	Gymnastics		
	Skiing		
	Softball		
	Volleyball		

B. **Student MAY participate in the following ONLY AFTER completing evaluation/rehabilitation:**

(Check all that apply.)

- ☐ **CONTACT/COLLISION**
- ☐ **LIMITED CONTACT**
- ☐ **NON-CONTACT/STRENUOUS**
- ☐ **NON-CONTACT/NON-STRENUOUS**

Please specify each condition requiring clearance before participating in a sport in the classification checked above:

CONDITIONS REQUIRING CLEARANCE BEFORE SPORTS PARTICIPATION INCLUDE, but are not limited to: Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral Valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney althlete; Hepatomegaly, Splenomegaly; Malignancy; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

EXAMINED BY:(Check one)

___ **Family Physician/ Provider** ___ **School Physician**

Circle license: MD DO CNP PA

Provider's Signature: ______________________________

Physician's Stamp Required

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NOTE FROM SCHOOL PHYSICIAN: The school physician has received the medical report from the student's medical home and it complies with the requirements of *N.J.A.C.* 6A:16-2.2.

School Physician's Initials/Stamp:______________________________ **Date:**_____/_____/_____ **Rev. 2004**