Athletic Department
Jason Morrell – Athletic Director
1600 Old Crown Pt. Road, West Deptford, NJ 08093
856-848-6110 ext. 2240 FAX: 856-848-1917

ATHLETIC PARTICIPATION SIGN OFF SHEET

Please sign at the bottom of this form after careful review. Your signature represents that you acknowledge and accept all language represented on the following forms. You can find these forms on our school website and additional copies may be obtained in the Athletic Office. ***All other attached forms must be filled out, signed and handed in to the Nurse's Office.***

THIS FORM MUST BE RETURNED TO THE ATHLETIC DEPARTMENT PRIOR TO PARTICIPATION

- **I, the parent/guardian of the named student, give my son/daughter permission to participate in all sports at West Deptford High School.**
- **Random Alcohol and Drug Testing Program Student Consent Form** (I have read the form/s and agree to all rules)
- **West Deptford District's Concussion Procedures & Guidelines for Return to Competition** (I have read the form/s and agree to all rules)
- **Sports-Related Concussion and Head Injury Fact Sheet and Parent/Guardian Acknowledgment Form** (I have read the form/s and agree to all rules)
- **NJSIAA Steroid Form** (I have read the form/s and agree to all rules)
- **ImPACT Testing Instructions – For first time WDHS athletes.** (I have read the form/s and agree to all rules)
- **ImPACT Consent Form** (I have read the form/s and agree to all rules)
- **Sudden Cardiac Death Pamphlet** (I have read the form/s and agree to all rules)
- **Sport Physical Information: I understand that one complete physical is required each year (every 365 days) in order for my son/daughter to participate in a sport/s. All physicals must be reviewed by our school doctor prior to participation in practices or competitions.**
- **Sport Physical Information: I understand that prior to each season (within the 365 days) a Health History Update Interim Form must be completed and turned in to the Nurse's Office.**
- **Equipment: All issued equipment is expected to be returned. Students whose equipment is LOST or STOLEN will be expected to PAY FOR IT; failure to do so will result in the student not participating in athletics until the equipment is accounted for.**
- **Injury Warning: I realize that such activities involve the potential for injury. Even with the use of reasonable care in coaching, protective equipment and observance of rules, physical hazards and injuries are possible. On rare occasions these physical hazards and injuries could result in total disability, paralysis, or even death.**
- **Insurance: Parents should be aware that student insurance coverage is limited by the terms and conditions of the policy and by the principle that payments are made only up to Usual and Reasonable Expenses. The latter means that doctors' fee and prices are not to exceed those generally charged in the locality for particular types of injuries and/or procedures.**
- **Academic Eligibility: In order to be academically eligible to participate in athletics, a students must have earned the following during each academic year: 15 credits at the conclusion of the 1st semester to participate in spring sports, and 30 credits at the conclusion of the 2nd semester (including summer school) to participate in sports during the 1st semester of the following school year.**

Print Student's Name:_____ **Grade:**____ **Sport(s):**_____

_____ _____ _____ _____

Student Signature **Date** **Parent/Guardian Signature** **Date**

Please return to the Athletic Office with payment

WEST DEPTFORD HIGH SCHOOL
STUDENT ACTIVITY FEE REMITTANCE FORM

1. All participants in athletics, band, and other eligible clubs will be assessed an annual fee due prior to the first practice or activity meeting. This fee covers sports, clubs, and co-curricular activities for the entire school year. There will be a fee of $50.00 for the first student in a family. For families with two or more participating children in the high school, there will be a $75.00 maximum family fee. Payment allows the students(s) to participate in all co-curricular activities offered that school year.

2. The user-fee for clubs, athletics and extra-curricular activities is non-refundable. Any participant who leaves a club, activity or team voluntarily or who is dropped for disciplinary reasons is not eligible for a refund.

3. If a student is not selected for a sport or activity, the activity fee will be refunded if it is the only activity in which the student plans to participate during the school year. The parent must request the refund in writing, and have the request signed by the principal. All refunds will be issued by the Business Office at the close of the school year.

4. All payments should be made by check or money order payable to the West Deptford Board of Education. Students who are eligible for free or reduced lunch may be approved for a fee waiver after petitioning through the principal's office.

5. Parents and students should understand that this fee entitles the participant to a place in an activity. It does not guarantee participation time in games, leads in performances, roles, positions, etc. These decisions will be made by the coaches and advisors. Fees collected are designed to help defray the cost of operating these activities. If a student is cut from (or chooses to leave) an activity before participation begins, the payment will be returned assuming that this is the only activity in which the student participated.

STUDENT ACTIVITY FEE REMITTANCE FORM

Please complete one form per family by **PRINTING** the information requested and returning the form and payment to the main office at the high school.

Student's Name	Grade	Fee
1.		$50.00
2.		$75.00
3.		$15.00 Reduced
4.		No fee

Parent/Guardian signature indicates he/she has read and understands the above information.

Parent name: _____ Signature: _____

Parent phone #: _____ Parent email: _____

West Deptford Athletic Training Office
856.848.6110 ext 2212

ImPACT™

ImPACT Testing Instructions

To ensure a valid test, please follow these instructions. It is very important that you are able to fully concentrate during the entire test. Poor performance will result in an invalid test and will require a re-take! The Customer ID code is: QF8MYTJFXW

- Set aside 30-45 minutes in a quiet room with no distractions to take the test.
- No headphones or cell phone use during the test. Turn off any televisions, radio, or anything else that can produce background noise.
- Tell siblings and family members about the importance of the test to avoid interruptions or distractions.
- Note: The test will begin by asking you background questions called the "demographic" section. There are 6 test sections called "modules." These include word memory, design memory, Xs and Os, symbol match, color word match, and three letters.
- Take your time to read each section's instructions very carefully. Each module is self explanatory. It is common to perform the color word match module incorrectly. Please read that section's instructions thoroughly.
- Other than the initial demographic section, do not ask anyone to help you with your performance during the test, such as assistance with memory questions, etc. Do not write anything down during the test to aid memory.
- You MUST use a standard external mouse. You may not use a finger mouse pad (i.e., laptop), a Track Mouse, or anything other than a standard mouse.
- Minimum computer requirements:
  - Make sure you are using Internet Explorer 6.0 and above, or Firefox 1.5 or above, and Safari for the MAC running OSX 10.2 and above.
  - You must have Macromedia FLASH PLAYER 8.0 or newer installed. You can download FLASH PLAYER at www.adobe.com.
  - If you have a pop up blocker installed, you must turn it off for the duration of the test.
  - Close all other programs on your computer before taking the test.
  - You need a broadband Internet connection.
- To take the baseline test, go to: **www.impacttestonline.com/testing**; enter the Customer ID Code (located at the top of this page), then click on "Launch Baseline Test."
- Make certain to select "**West Deptford High School**" when asked for "school/organization" in the demographic section.
- Your test results are not displayed once you are finished (all results are password protected). See Ms. English if you are interested in your baseline results.
- Please note our test contract with ImPACT does NOT allow for unlimited baseline tests. Please do not allow others to take an additional test.
- If you do not have access to the Internet or a home computer that meets the above requirements, contact Ms. English or the Athletic Department to arrange a testing time at school.
- **Return your ImPACT test receipt to Mr. Panchella or to the Athletic Office once you have completed the test.**
- Thank you for participating in our ImPACT Concussion Management Program.

WDHS Nurse's Office
Nurse – Lynn Zoll, BSN, RN
Phone: 856-848-6110 ext 2240
Fax: 856-384-5825

Information on Completing Physicals

When obtaining and completing a physical form:
The main physical form has some areas of attention for the athlete and parent/guardian.

a. The **History Form** page must be completed, and then reviewed by the examining provider. The parent/guardian signature is required along with the athlete's.
b. The **Physical Examination Form**, must be filled out in its entirety. Anything missing from it will keep the athlete from participating in a sport. Please make certain that your examining physician has filled out the form properly and that **nothing is missing** , including the area where ***vision,*** blood pressure, height, pulse, etc. are listed. (Note that if you decline your child's visual exam by the examining provider, you must attach their visual acuity from their eye doctor.) ***Only a licensed provider with MD, DO, APN or PA can fill in this form. The physical must be completed and signed by a provider who has completed the Student-Athletic Cardiac Assessment Professional Development Module.*** Please note that the History Form must be filled out and attached to the Physical Examination Form when your provider does the medical exam.
c. The **Clearance Form** must be filled out in its entirety by the examining provider, including the provider's stamp and date of exam.
d. **Neither copies nor faxes will be accepted.** A physical form is not complete unless all pages are handed in together.

When utilizing a previous physical:
Athletes may use a physical obtained in a previous year (less than 364 days before start date), but you must do the following.

a. Complete all pages in their entirety (see above directions.)
b. The entire History Form, Physical Examination Form and Clearance Form must be filled out (**neither copies nor faxes will be accepted.**) Note that date of exam must be presented in all areas as a record that permits 364 day check.
c. If the 365th day after the physical is after the NJSIAA start date (first practice for your sport), then the physical is acceptable for the entire season; if not, a whole new physical examination is required.
d. A completed Physical Questionnaire/Permission and Drug Test Form (first sport of the year only)
e. Parent must complete Health History Update Questionnaire.

ATTENTION PARENT/GUARDIAN: The preparticiaption 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

This form must be returned to the Nurse's Office!

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep 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 _____

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practician 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).

Note that if you decline your child's visual exam by the examining provider, you must attach their visual acuity from their eye doctor!

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 in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

Date of Exam _____

☐ 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 _____

Address _____ Phone _____

Signature of physician, APN, PA _____

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

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). Date of Exam _____

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 _____

©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

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