West Milford Township Public Schools
West Milford, New Jersey 07480

Office of the School Nurse

RELEASE OF MEDICAL INFORMATION CONSENT FORM Confidential

Student's Name: _____
(Please Print)

Parent/Legal Guardian Name: _____
(Please Print)

Please check one:

___ I authorize the West Milford Township School Nurses to disclose to the West Milford Township School District employees, (i.e., faculty, staff, coaches) and volunteers, on a need to know basis, medical Information from my child's health record: (i.e., medical conditions, allergies, medications).

Or

___ I do not authorize: The West Milford Township School Nurses to disclose information from my child's health record to West Milford Township School District employees, (i.e., faculty, staff, coaches) and volunteers and take full responsibility to disclose information to West Milford Township School District Employees and/or volunteers.

Parent or Legal Guardian Signature_____Date: _____

This consent to disclose information will be valid during your student's entire period of enrollment in West Milford Township Public Schools. It is the responsibility of the parent/guardian to update this information whenever the student's medical condition/information changes.

WEST MILFORD PUBLIC SCHOOLS

46 Highlander Drive, West Milford, New Jersey 07480
Phone: 973-697-1700 www.wmtps.org Fax: 973-697-8351

Brian Kitchin, Ed.D.
Superintendent

William Scholts
Administrator/Board Secretary

Daniel Novak
Director of Education

Derek Ressa, Ed.D.
Interim Director of Special Services

"Success Starts Here"

School _____ Grade_____

Student's Name_____Gender_____Date of Birth_____

Address_____Telephone Number_____

Mother's Name_____Fathers Name_____

# of Brothers_____# of Sisters_____Birth Order of Student_____

With whom does your child live with_____

Pediatrician _____ Date of Last Exam _____

Has your child had any of the following:

Disease	Date	Disease	Date
Lymes Disease		Heart Condition	
Diabetes		Ear tubes/tonsillectomy	
Seizures		Tourette's Syndrome	
Asthma		ADHD	
COVID-19		Developmental Delays	
Autism		Orthopedic/Mobility Issue	
Vision Issues		Hearing Issues	
Other:			

Does your child take any medications? Please list _____

_____

Does your child have any allergies? If so please list allergen and type of reaction _____

_____

Does your child have any dietary restrictions? _____

_____

Has your child ever had surgery? Explain:_____

Has your child ever been hospitalized? Please explain_____

_____

Has your child ever had a formal eye exam? _____ If yes explain_____

Does your child wear corrective lenses? Yes ___ No ___

Last dental exam _____

Do you have any medical concerns about your child that you would like the school nurse to be aware of?

_____

_____

_____

_____

_____

Parent signature _____ Date _____

School nurse signature _____ Date _____

WEST MILFORD TOWNSHIP PUBLIC SCHOOLS
BOARD OF EDUCATION
46 HIGHLANDER DRIVE
WEST MILFORD, NJ 07480

Printed Name of Parent/Guardian:_____

ACKNOWLEDGEMENT OF PHYSICAL REQUIREMENT

Date: _____

Dear Parent/Guardian:

New Jersey Law mandates that every student entering a New Jersey public school, regardless of the transferring locations, must present a physical exam signed by a licensed physician. The physical must have been completed within 365 days prior to the first day of school, and it is due in the nurse's office within 30 days of registration. Please make sure you provide the nurse with a written exam report as soon as possible. Your signature below indicates that you have been informed of this policy.

Thank you for your cooperation and attention to this matter.

West Milford Township Public Schools

_____
Parent/Guardian Signature

Revised 11/2017

WEST MILFORD TOWNSHIP PUBLIC SCHOOLS
STUDENT PHYSICAL EXAMINATION

Date of Exam_____

NAME_____ BIRTH DATE_____ GRADE_____ SEX M_____ F_____

ADDRESS_____ HEIGHT_____ WEIGHT_____

EARS_____ EYES_____ LYMPH GLANDS_____ THYROID_____

NOSE_____ THROAT_____ TEETH/MOUTH_____ HEART_____

LUNGS_____ ABDOMEN_____ HERNIA_____

GENITO-URINARY_____ SPINE/SCOLIOSIS_____ FEET/POSTURE_____

SKIN_____ NUTRITION_____ NERVOUS SYSTEM_____ SPEECH_____

OTHER_____ GENERAL APPEARANCE_____

BP_____ HEARING R_____ L_____ VISION R_____ L_____

**CODE: N-Normal X-Needs Attention

PAST HISTORY

DISEASE	AGE
Chicken Pox	
German Measles	
Measles	
Mumps	
Strep Infections	
MRSA	
Pneumonia	
Asthma	
Tuberculosis or Contact	
Otitis Media	
Heart Disease	
Epilepsy/Seizure Disorder	
Congenital Defect	
Rheumatic Fever	
Lyme Disease	
Lead Poisoning	
Allergies: Foods	
Pollen, Grass, Weeds, etc.	
Medications	
Injuries:	
Surgery:	
Hospitalizations:	
Comments:	

Mantoux/TB Test
Date Adm._____ Results:_____

Please circle the appropriate vaccine and types given below for the DPT and Polio sections. It is required by the NJDOH.

IMMUNIZATION RECORD

VACCINE (circle one)	Date Given (Month/Day/Year)
DT DTP Dtap 1	
DT DTP Dtap 2	
DT DTP Dtap 3	
DT DTP Dtap 4	
DT DTP Dtap 5	
TDAP	
OPV IPV 1	
OPV IPV 2	
OPV IPV 3	
OPV IPV 4	
MMR 1	
MMR 2	
HIB 1	
HIB 2	
HIB 3	
HIB 4	
HEP B 1	
HEP B 2	
HEP B 3	
VARICELLA 1	
VARICELLA 2	
PNEUMOCOCCAL CONJUGATE	
INFLUENZA	
MENIMUNE MENACTRA	
GARDISIL	
HEP A 1	
HEP A 2	

Physician's Signature_____

Phone No.:_____

Date:_____

Print or Stamp M.D. name:

KINDERGARTEN PHYSICAL AND IMMUNIZATIONS MUST BE UP-TO-DATE, COMPLETED AND SUBMITTED PRIOR TO SCHOOL ENTRY.

Revised 11/05/08

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student-Athlete Cardiac Assessment Professional Development module hosted by the New Jersey Department of Education.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	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 either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions 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?		
HEART 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.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)		Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?			
10. Have you ever had a seizure?			
HEART 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?			

BONE 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?		

MEDICAL 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?		
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? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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: _____

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The Medical Eligibility Form is the only form that should be submitted to a school.

■ PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name:_____ Date of birth: _____

1. Type of disability:
2. Date of disability:
3. Classification (if available):
4. Cause of disability (birth, disease, injury, or other):
5. List the sports you are playing:

	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or 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 as having 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 whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (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 questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

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■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

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, 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	**NORMAL**	**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		

[a] 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: _____, MD, DO, NP, or PA

Preparticipation Physical Evaluation Medical Eligibility Form

The Medical Eligibility Form is the only form that should be submitted to school. It should be kept on file with the student's school health record.

Student Athlete's Name _____ Date of Birth _____

Date of Exam _____

- o Medically eligible for all sports without restriction
- o Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of
- o Medically eligible for certain sports
- o Not medically eligible pending further evaluation
- o Not medically eligible for any sports

Recommendations: _____

I have reviewed the history form and examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings- are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Signature of physician, APN, PA _____ Office stamp (optional)

Address: _____

Name of healthcare professional (print) _____

I certify I have completed the Cardiac Assessment Professional Development Module developed by the New Jersey Department of Education.

Signature of healthcare provider _____

Shared Health Information

Allergies _____

Medications:

Other information: _____

Emergency Contacts: _____

**This form has been modified to meet the statutes set forth by New Jersey.*

West Milford Township Public Schools

Good oral health care for your child is an investment in his/her health that will pay lifelong dividends. Regular dental check-ups are an important part of proper oral care. Please have your child's dentist complete this form and return it to the health office.

Report of Dental Examination

Date:_____

Student's Name_____ Age_____

Grade/Teacher _____

Results of Dental Examination

_____ All necessary dental care has been rendered

_____ The child is receiving dental treatment

Comments_____

Date of next dental visit recommended_____

Signature of Dentist_____

Dentist's Printed Name and Address Stamp

Dentist's Telephone No._____