BERNARDS HIGH SCHOOL REGISTRATION REQUIREMENTS

□ Proof of Residency (need one of the following)

a) Property tax bill for property of Parent/Guardian
b) Deed for property of Parent/Guardian
c) Contract of sale for property of Parent/Guardian
d) Lease in Parent/Guardian's name
e) Notarized affidavit from owner/landlord of Parent/Guardian residence

In addition to one of the above documents, please bring two pieces of mail (i.e., utility bill, phone bill) that come to you at that address.

NOTE: If the family resides in Bedminster, they must first call the Bedminster School for an appointment to establish residency. The number is (908) 234-0768. Bedminster will provide a letter to the parent/s showing proof of residency which shall be presented to the high school at time of registration.

□ Immunization Records

A certified record showing compliance of all State of New Jersey mandated immunizations is required. This can be in the form of an official school record (NJ School record A45) from your previous school indicating month/date/year of required immunization. It can also be a physician certified record indicating month/date/year of each required immunization. If your son's/daughter's immunization records are not in English, you must submit a translated copy certified by a physician. Lists of required immunizations are available on the State of NJ website which can be accessed through this link:
https://www.nj.gov/health/cd/documents/imm_requirements/k12_parents.pdf

https://www.nj.gov/health/cd/documents/imm_requirements/vaccine_qa.pdf

□ Proof of Current Physical Examination

Upon registration, a physical examination is required for all students new to the district. It must be dated within 365 days of enrollment and performed by a professional licensed to practice medicine or osteopathy, or by an advanced practice nurse in the state of NJ. It should contain an appropriate history and physical evaluation and state what, if any, modifications should be followed for full participation in all school activities. The four page NJ State Annual Pre-Participation Physical Evaluation and Health History Update Questionnaire is the suggested documentation that should be completed and submitted. Link for this form can be accessed:

https://www.state.nj.us/education/students/safety/health/records/athleticphysicalsform.pdf

https://www.state.nj.us/education/students/safety/health/records/HealthHistoryUpdate.pdf

https://www.njsiaa.org/sites/default/files/document/Pre-participation%20Form%20in%20Spanish.pdf

□ Proof of Age – Birth Certificate or Passport

□ Unofficial transcript and/or report card from previous school

Requisitos para Matricularse
Bernards High School

- **Prueba de Residencia (necesita uno de los siguientes)**
  a) Factura del impuesto de la propiedad del Padre/Tutor
  b) Escritura de la propiedad del Padre/Tutor
  c) Contrato de venta de la propiedad del Padre/Tutor
  d) El contrato de arrendamiento en nombre del Padre/Tutor
  e) Declaración jurada notariada del propietario/dueño de la residencia del Padre/Tutor

  Además de uno de los documentos anteriores, traiga dos facturas que recibe en el correo (por ejemplo, factura de servicios públicos, factura de teléfono) que le lleguen a esa dirección.

  NOTA: Si la familia reside en Bedminster, primero debe llamar a la Escuela de Bedminster para hacer una cita para establecer la residencia. El número de teléfono es (908) 234-0768. Bedminster proporcionará una carta a los padres mostrando prueba de residencia que se presentará a la escuela secundaria al momento de la registración.

- **Registros de Inmunización**

Se requiere un registro certificado que demuestre el cumplimiento de todas las vacunas obligatorias del Estado de Nueva Jersey. Esto puede ser en forma de un registro escolar oficial (registro escolar de NJ A45) de su escuela anterior indicando el mes/fecha/año de vacunación requerida. También puede ser un registro certificado por un médico que indique el mes/fecha/año de cada vacuna requerida. Si los registros de vacunación de su hijo(a) no están en inglés, debe enviar una copia traducida certificada por un médico. Las listas de vacunas requeridas están disponibles en el sitio web del Estado de NJ, las cuales se pueden encontrar a través de este enlace:

https://www.nj.gov/health/cd/documents/imm_requirements/k12_parents.pdf
https://www.nj.gov/health/c/documents/imm_requirements/vaccine_qa.pdf

- **Prueba de Examen Físico reciente**

Al momento de la registración, se requiere un examen físico para todos los estudiantes nuevos en el distrito. Debe estar fechado durante el año de la registración y debe ser hecho por un profesional con licencia para practicar medicina u osteopatía, o por una enfermera de práctica avanzada en el estado de NJ. Debe contener un historial y una evaluación física apropiada e indicar qué modificaciones, si las hay, deben seguirse para participar completamente en todas las actividades escolares. El documento de cuatro páginas del *NJ State Annual Pre-Participation Physical Evaluation* y el documento *Health History Update Questionnaire* debe completarse y enviarse. Aquí se puede encontrar el enlace de este formulario:

https://www.state.nj.us/education/students/safety/health/records/athleticphysicalsform.pdf
https://www.state.nj.us/education/students/safety/health/records/HealthHistoryUpdate.pdf
https://www.njsiaa.org/sites/default/files/document/Pre-participation%20Form%20in%20Spanish.pdf

- **Prueba de Edad – Certificado de Nacimiento o Pasaporte**

- **Transcripción no-oficial y/o boleta de calificaciones de la escuela anterior**

THE SOMERSET HILLS SCHOOL DISTRICT

Entrance Registration

Part 1: Student Information:

Student's Legal Name _____ **Date of Birth:** _____
(last, first, middle)

Residence Street, City, Zip _____ **Gender:** M F

Mailing address (if different) _____ **Siblings in District (name & grade)**
(street, city, state, zip)

1 _____

Ethnic Background (*Required* – Please check all that apply. See end of form for explanation.) 2 _____

___American Indian/Alaskan Native ____Native Hawaiian/Pacific Islander ___Asian 3 _____

___Black or African American ____White or Caucasian

___Hispanic or Latino

Country of Birth _____ **State of Birth** _____ **City of Birth** _____

What was the first language your child learned to speak? _____

Please indicate the primary language spoken at home, regardless of the language spoken by the student:

English____ **Spanish**_____ **Other**_____**(please specify)**

What is the language most often spoken by the student? _____

Would you like to receive alert messages from the school in Spanish? Y N

Part 2: Parent Information:

Parent(s)/Guardian(s) with whom student resides:

Name_____ **Relationship**_____ **Cell Phone**_____

Name_____ **Relationship**_____ **Cell Phone**_____

Home Telephone _____ **Other Telephone** _____ **(specify)**

Mother email address _____**Father email address** _____

If student does not reside with parent(s), proof of legal custody or guardianship papers must be attached*

Information about non-resident parent (if applicable):

Name_____ **Relationship**_____

Mailing address_____ **City, State, Zip**_____

Home Phone_____ **Cell or Business Phone**_____ **Addl mailing required Y N**

Does child have Health Insurance?
Yes _____ **If yes, name of insurance company** _____

No _____ **NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information call 800-701-0710 or visit www.njfamilycare.org to apply online.**

You may release my name and address to the NJ FamilyCare Program to contact me about health insurance.

Signature: _____ **Printed Name** _____ **Date** _____

Written consent required pursuant to 20 U.S.C. § 1232g (b)(1) and 34 C.F.R. 99.30 (b).

Part 3: School information

Grade registrant is entering:_____ **Last grade completed:**_____

School name and address transferring from:_____

_____
(city, state)

What date did your child first enter a U.S. School (mm/dd/yyyy)? _____

Is your child currently receiving, or has your child ever received special education services through the school? Y N

Does your child currently have an IEP (Individual Educational Program)? Y N

Has your child ever been excluded from school as a result of a weapons charge? Y N

Has the registrant ever attended school in the Somerset Hills School District? Y N If Yes, Grades attended_____

I certify that the information provided herein is true and accurate:

Signature of parent or legal guardian_____ **Date** _____

Explanation of ethnicity questions:

Hispanic or Latino *– A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture origin, regardless of race.*

American Indian or Alaska Native *– A person having origins in any of the original people of North and South America (including Central America) and who maintains a tribal affiliation or community attachment.*

Asian *– A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.*

Black or African American *– A person having origins in any of the black racial groups of Africa.*

Native Hawaiian or Other Pacific Islander *– A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.*

White or Caucasian *– A person having origins in the original peoples of Europe, the Middle East, or North Africa.*

For Office Use Only

Type of Proof of Residency Submitted:_____ **Type of DOB proof:**_____

Starting date: _____ **Student #:**_____ **Counselor:**_____ **Homeroom:** _____

Copies made of original documents to be placed in file:_____ **Date:** _____

SOMERSET HILLS SCHOOL DISTRICT

AFFIDAVIT OF OWNER/LANDLORD

Landlord Information	**Tenant Information**
Name of Landlord:	*Name of the Family:*
Street Address:	*Street Address:*
City:	*City:*
Phone Number(s):	*Phone Number(s):*
Lease Information	
Please specify the terms of the lease: Relation to Renter: ___ No Relation ___ Family Member(s) When did the tenant(s) move in? ___/___/___ How long is the agreement effective? Until: ___/___/___ What kind of rental agreement? _____	
List the names of all persons living in the apartment/house:	

I attest that, to the best of my knowledge, the information is true and correct and I am aware that fraudulent statements or claims may be prosecuted to the full extent of the law.

Swom and subscribed before me this

_____ day of _____

_____ *Signature of Tenant*

_____ *Date*

_____ *Signature of Landlord*

_____ *Date*

_____

Notary Public of New Jersey

RELEASE OF RECORDS

BERNARDS HIGH SCHOOL
Somerset Hills School District
Phone #908-204-1930 x2347 Fax #908-766-8223

I hereby give my permission for

_____
Name of School

_____
Street (Mailing) Address

_____
Town State Zip Code

to send all records (HEALTH RECORDS, STANDARDIZED TEST RESULTS, PAST AND CURRENT REPORT CARDS, SPECIAL SERVICES RECORDS) for the child(ren) listed below who have registered in our school:

1. _____ Grade _____
2. _____ Grade _____
3. _____ Grade _____
4. _____ Grade _____
5. _____ Grade _____

Send complete records to: **Registrar**
Bernards High School
25 Olcott Avenue
Bernardsville, NJ 07924

****You must include the completed A41 form – Student Transfer Card***

_____ _____
Signature Date

NEW JERSEY STATE INTERSCHOLASTIC ATHLETIC ASSOCIATION

1161 Route 130 North, Robbinsville, NJ 08691-1104

STUDENT-ATHLETE RESIDENCY AFFIDAVIT

Print Student's Full Name	School	Date

I, _____, of full age, being duly sworn to law, upon my oath depose and say:

1. I am the parent/legal guardian of the above listed student. (circle)
2. I currently reside at: _____

   I have resided at the above address since: _____
3. The above-named student moved with me at my new address on: _____
4. Prior to moving to the new residence address listed above, I resided at the following address:

   _____
5. Prior to moving to the new address listed in #2 above, the student resided at the following address:

   _____

   with named parent/legal guardian _____
6. I hereby authorize the New Jersey State Interscholastic Athletic Association ("NJSIAA") to investigate and confirm any and all Statements made by me in this affidavit. I agree to provide any additional information that may be requested by the NJSIAA.
7. I will notify the present school immediately, in writing, if any of the conditions recited herein are changed.
8. This residence may not be associated with, leased, or provided by anyone associated with the school or acting at the direction of the school, including but not limited to administration, staff, coaches, students, parents, booster clubs, or any organization having a connection with the school.

I hereby certify that the forgoing statements are true, and I am aware that if any of the foregoing statements are willfully false, I am subject to punishment.

Parent/Guardian Signature	Print Parent/Guardian Full Name

STATE OF NEW JERSEY, COUNTY OF _____. The above-named affiant appeared before me, a notary public of the State of New Jersey, on the _____ day of _____, 20_____ and I made known to him/her the contents of the above affidavit which was then sworn and subscribed to by said affiant before me on this date.

Notary Public: _____

Copies of this Affidavit must be sent to the New Jersey State Interscholastic Athletic Association upon request

EC Approved 4/1/20

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

BERNARDS HIGH SCHOOL
25 OLCOTT AVENUE
BERNARDSVILLE, NEW JERSEY 07924

TO ALL STUDENTS

All Bernards High School students must pay a one-time fee of seventy-five ($75.00) dollars per school year for participation in any number of athletic and/or extra-curricular activities. For example, the $75.00 fee would cover participation in al sport seasons, as well as membership in a club or clubs, for the entire school year.

If you plan to participate in any athletic or co-curricular activity, please complete the form below and return it with your $75.00 check or money order (no cash will be accepted) payable to Bernards High School. If you wish to make a donation to the Bernards Athletic Booster Club please add $25.00 to your payment. The form and payment should be returned to Mrs. Malzone in the Athletic Office. You can also make your payment using a credit card via RevTrak. This option is on the district home page; choose Parents, click On Line Payments.

If you have any questions, please call Mr. Hoppe, Assistant Principal/Athletic Director, at 908-204-1930 x 2101.

Thank you.

****

Student Name: _____

Grade: _____

Activity/Sport: _____

Return this form ONLY if you DO NOT want your child to be photographed

The Somerset Hills School District
25 Olcott Avenue
Bernardsville, NJ 07924

Date:_____

I **DO NOT** want The Somerset Hills School District, or anyone authorized by The Somerset Hills School District, to use and reproduce photographs/videos of my child participating in school events for use in the newspapers or Somerset Hills School District publications.

Student:_____
Grade:_____

Address:_____
City:_____State:_____
_ Zip:_____

Signature of Parent or
Guardian:_____

(If this form is not returned, The Somerset Hills School District understands permission is granted for use of all photographs/videos.)

SOMERSET HILLS SCHOOL DISTRICT

Acceptable Use of Computer Network / Computers and Resources Form

August 2019

Dear Parent or Guardian,

This document provides information regarding The Somerset Hills School District's (SHSD) procedures for students to utilize electronic resources.

Part of the district's responsibility in successfully preparing all students for the future is to provide them with access to tools they will use as adults. For example, the Internet includes communication and information networks that were originally created for university-level research. However, it has evolved into a significant learning tool for students of all ages.

These additional educational opportunities also bring increased responsibilities. The district has established procedures and rules regulating the use of SHSD electronic resources. Students are instructed to practice responsible equipment usage. Students are also directed to only access instructionally appropriate content through the Internet. SHSD uses a sophisticated filtering system to help prevent access to inappropriate content.

It is important that both you and your child read, discuss, and understand The Somerset Hills School District Policies and Regulations listed below:

- 2361 – Acceptable Use of Computer Network / Computers and Resources
- 2363 – Pupil Use of Privately Owned Technology.
- 7523 – School District Provided Technology Devices to Pupils

These documents can be accessed on the district's website as well as in each school's main office. Your signature below must be provided before your child is given access to SHSD electronic resources, including the Internet.

Thank you for your prompt attention to this matter.

Mark Prunty
District Information Technology Manager
mprunty@shsd.org
908-204-1930 x2168

I have reviewed The Somerset Hills School District Policy and Regulation 2361 - Acceptable Use of Computer Network / Computers and Resources, Policy 2363 – Pupil Use of Privately Owned Technology, and Policy 7523 – School District Provided Technology Devices to Pupils, and give permission for my child to use SHSD electronic resources, including the Internet. Please return signed form to the location listed below for your child's school.

Student's Name (Print) Grade

Student's Signature Date

Parent's/Guardian's Signature Date

Bedwell Elementary	Bernardsville Middle	Bernards High
Main Office	Period 1 Teacher	Main Office

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 _____

HE0503 9-2681/0410

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

EVALUACIÓN FÍSICA – PRE-PARTICIPACIÓN

FORMULARIO DE HISTORIAL MÉDICO

(Nota: Este formulario debe ser rellenado por el paciente y padre/madre antes de ver al doctor. El doctor debe mantener este formulario en el expediente)

Fecha del examen _____

Nombre _____ Fecha de nacimiento _____

Sexo _____ Edad _____ Grado _____ Escuela _____ Deporte(s) _____

Medicamentos y Alergias: Por favor, indica todos los medicamentos con y sin receta médica y suplementos (herbales y nutricionales) que estás tomando actualmente

_____

_____

_____

Tienes alergias ☐ Sí ☐ No Si la respuesta es sí, por favor identifica abajo la alergia específica.
☐ Medicamentos ☐ Polen ☐ Comida ☐ Picaduras de insecto

Explica abajo las preguntas respondidas con un "sí". Pon un círculo alrededor de las preguntas cuyas respuestas desconoces.

PREGUNTAS GENERALES	Sí	No
1. ¿Alguna vez un doctor te ha prohibido o limitado tu participación en deportes por alguna razón?		
2. ¿Tienes actualmente alguna condición médica? Si es así, por favor identifícala abajo: ☐ Asma ☐ Anemia ☐ Diabetes ☐ Infecciones Otro: _____		
3. ¿Has sido ingresado alguna vez en el hospital?		
4. ¿Has tenido cirugía alguna vez?		
PREGUNTAS SOBRE LA SALUD DE TU CORAZÓN	**Sí**	**No**
5. ¿Te has desmayado alguna vez o casi te has desmayado DURANTE o DESPUÉS de hacer ejercicio?		
6. ¿Has tenido alguna vez molestias, dolor o presión en el pecho cuando haces ejercicio?		
7. ¿Alguna vez has sentido que tu corazón se acelera o tiene latidos irregulares cuando haces ejercicio?		
8. ¿Te ha dicho alguna vez un doctor que tienes un problema de corazón? Si es así, marca el que sea pertinente ☐ Presión alta ☐ Un soplo en el corazón ☐ Nivel alto de colesterol ☐ Una infección en el corazón ☐ Enfermedad de Kawasaki ☐ Otro:		
9. ¿Alguna vez un doctor te ha pedido que te hagas pruebas de corazón? (Por ejemplo, ECG/EKG, ecocardiograma)		
10. ¿Te sientes mareado o te falta el aire más de lo esperado cuando haces ejercicio?		
11. ¿Has tenido alguna vez una convulsión inexplicable?		
12. ¿Te cansas más o te falta el aire con más rapidez que a tus amigos cuando haces ejercicio?		

PREGUNTAS SOBRE LA SALUD DEL CORAZÓN DE TU FAMILIA	Sí	No
13. ¿Has tenido algún familiar que ha fallecido a causa de problemas de corazón o que haya fallecido de forma inexplicable o inesperada antes de la edad de 50 años (incluyendo ahogo, accidente de tráfico inesperado, o síndrome de muerte súbita infantil)?		
14. ¿Sufre alguien en tu familia de cardiomiopatía hipertrófica, síndrome Marfan, cardiomiopatía arritmogénica ventricular derecha, síndrome de QT corto, síndrome de Brugada, o taquicardia ventricular polimórfica catecolaminérgica?		
15. ¿Alguien en tu familia tiene problemas de corazón, un marcapasos o un desfibrilador implantado en su corazón?		
16. ¿Ha sufrido alguien en tu familia un desmayo inexplicable, convulsiones inexplicables, o casi se ha ahogado?		
PREGUNTAS SOBRE HUESOS Y ARTICULACIONES	**Sí**	**No**
17. ¿Alguna vez has perdido un entrenamiento o partido porque te habías lesionado un hueso, músculo, ligamento o tendón?		
18. ¿Te has roto o fracturado alguna vez un hueso o dislocado una articulación?		
19. ¿Has sufrido alguna vez una lesión que haya requerido radiografías, resonancia (MRI) tomografía, inyecciones, terapia, un soporte ortopédico/tablilla, un yeso, o muletas?		
20. ¿Has sufrido alguna vez una fractura por estrés?		
21. ¿Te han dicho alguna vez que tienes o has tenido una radiografía para diagnosticar inestabilidad del cuello o inestabilidad atlantoaxial? (Síndrome de Down o enanismo)		
22. ¿Usas regularmente una tabilla/soporte ortopédico, ortesis, u otro dispositivo de asistencia?		
23. ¿Tienes una lesión en un hueso, músculo o articulación que te esté molestando?		
24. ¿Algunas de tus articulaciones se vuelven dolorosas, inflamadas, se sienten calientes, o se ven enrojecidas?		
25. ¿Tienes historial de artritis juvenil o enfermedad del tejido conectivo?		

(Por favor, continúe)

PREGUNTAS MÉDICAS	Sí	No
26. ¿Toses, tienes silbidos o dificultad para respirar durante o después de hacer ejercicio?		
27. ¿Has usado alguna vez un inhalador o has tomado medicamento para el asma?		
28. ¿Hay alguien en tu familia que tenga asma?		
29. ¿Naciste sin o te falta un riñón, un ojo, un testículo (varones), el bazo, o algún otro órgano?		
30. ¿Tienes dolor en la ingle o una protuberancia o hernia dolorosa en el área de la ingle?		
31. ¿Has tenido mononucleosis (mono) infecciosa en el último mes?		
32. ¿Tienes algún sarpullido, llagas, u otros problemas en la piel?		
33. ¿Has tenido herpes o infección de SARM en la piel?		
34. ¿Has sufrido alguna vez una lesión o contusión en la cabeza?		
35. ¿Has sufrido alguna vez un golpe en la cabeza que te haya producido una confusión, dolor de cabeza prolongado, o problemas de memoria?		
36. ¿Tienes un historial de un trastorno de convulsiones?		
37. ¿Tienes dolores de cabeza cuando haces ejercicio?		
38. ¿Has tenido entumecimiento, hormigueo, o debilidad en los brazos o piernas después de haber sufrido un golpe o haberte caído?		
39. ¿Has sido alguna vez incapaz de mover los brazos o las piernas después de haber sufrido un golpe o haberte caído?		
40. ¿Te has enfermado alguna vez al hacer ejercicio cuando hace calor?		
41. ¿Tienes calambres frecuentes en los músculos cuando haces ejercicio?		
42. ¿Tienes tú o alguien en tu familia el rasgo depranocítico o la enfermedad drepanocítica?		
43. ¿Has tenido algún problema con los ojos o la vista?		
44. ¿Has sufrido alguna lesión o daño en los ojos?		
45. ¿Usas lentes o lentes de contacto?		
46. ¿Usas protección para los ojos, tal como lentes protectoras o un escudo facial?		
47. ¿Te preocupa tu peso?		
48. ¿Estás intentando aumentar o perder de peso o alguien te ha recomendado que lo hagas?		
49. ¿Estás siguiendo alguna dieta especial o evitas ciertos tipos de comida?		
50. ¿Has tenido alguna vez un trastorno alimenticio?		
51. ¿Tienes alguna preocupación de la que quieras hablar con el doctor?		

SÓLO PARA MUJERES	Sí	No
52. ¿Has tenido alguna vez el período menstrual?		
53. ¿Qué edad tenías cuando tuviste tu primer período menstrual?		
54. ¿Cuántos períodos has tenido en los últimos 12 meses?		

Explica aquí las preguntas a las que respondiste con un "sí"

Yo por la presente declaro que, según mi más leal saber y entender, mis respuestas a las preguntas anteriores están completas y son correctas.

Firma del atleta _____

Firma del padre/madre/tutor legal _____

Fecha _____

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

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 _____

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

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

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 _____

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).

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 _____

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

Bernards High School

Mr. Michael Hoppe
Assistant Principal
(908) 204-1930 Ext. 2101

Dr. Scott Neigel
Principal
(908) 630-3001

Dr. Michael Corbett
Assistant Principal
(908) 204-1930 Ext. 2

Health Clinics near Bernardsville, NJ

Family Health Center Pediatrics
Dr. Donald Hoezel
200 South St.
Morristown, NJ 07960
973-889-6805

Plainfield Health Clinic
Neighborhood Health Services
1700 Myrtle Ave.
Plainfield, NJ
908-753-6401

Zufall Health Center
2-4 Atno Ave.
Morristown, NJ 07960
973-267-0002

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- **Child health education for parents/guardians**

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Promoting Public Health

Bernards Township Health DEPARTMENT

Bernards Township HEALTH Department,
262 S. Finley Ave., Basking Ridge, NJ 07920
P. 908-204-2520 F. 908-204-3075
www.bernardshealth.org

Contractual Health Agency for:
Bernards Township
Bernardsville Borough
Chester Borough
Long Hill Township
Mendham Borough
Peapack and Gladstone Borough