INTERESTED IN PLAYING SPORTS?

The College of Saint Elizabeth Athletic Department partners with Atlantic Sports Health. Below is a checklist that should be utilized by first time or transfer student-athletes who are looking to participate in sports in the fall, winter, or spring season(s).

☐ Initial medical evaluation and clearance completed by YOUR primary care physician and turned in to the athletic trainer by June 15th at the latest


AND IN ADDITION

☐ Traditional Undergraduate Student NJ and CSE Medical Requirement

Health Forms and Immunization Forms must be completed and returned to the health service by June 15th forms located at:

http://www.cse.edu/medreqs or http://www.cse.edu/medforms

☐ EKG, blood work w/ CBC analysis, urine analysis and sickle cell trait testing

☐ ALL detailed paperwork disclosing significant medical conditions (i.e. anemia, sickle cell trait, cardiac conditions, injuries, concussions, sprains, strains, surgery, family history of illness or special consideration for activity, MRI reports, surgical notes, and specialty doctor clearances, etc.)

☐ Final evaluation, clearance, and physical by Atlantic Sports Health obtained through the College of Saint Elizabeth Athletic Department

☐ Once all paperwork and clearances are received and reviewed final clearance will be determined

Any medical questions can be directed to
Michael Pawlusiak, Head Athletic Trainer mpawlusiak@cse.edu (973)290-4288 (Phone) (973)290-4217 (FAX)

All other questions regarding athletic eligibility should be directed to
Juliene Simpson, Director of Athletics jsimpson@cse.edu (973)290-4207 (Phone)
Dear Physician:

Please complete in full the pre-participation history and physical. Be aware NCAA level sports require a high level of physical involvement both in training activities and competitive play. Please evaluate and explain all significant medical history in detail before allowing the athlete to participate.

- Describe the history and physical findings, evaluations, treatments, management and follow-up care of their medical history and physical findings.

Include additional sports clearance from specialists as required and indicated;
- i.e. shoulder, knee, back injury or surgery - requires orthopedist evaluation & clearance
- i.e. heart murmur, arrhythmia, syncope - requires cardiac evaluation & clearance
- i.e. concussions, seizure disorder – requires neurologist evaluation & clearance

  o Include:
    diagnosis and summary of evaluation, treatment, management, follow-up care, limitation, restrictions if any and clearance to participate in a NCAA level sport.

When considering clearance the athlete’s medical condition and functional abilities, and the demands of the sport, need to be taken into consideration.
ATHLETIC PRE-PARTICIPATION HISTORY AND PHYSICAL EXAMINATION

STUDENT-ATHLETE INSTRUCTIONS

Dear Student-Athlete:

The NCAA requires a comprehensive ATHLETIC PRE-PARTICIPATION HISTORY AND PHYSICAL EXAMINATION no more than 6 months prior for participation.

Please complete the attached forms and return them to the athletic office no later than June 15th for the fall semester.

It is important for all athletes to be able to participate at the first scheduled practice. Without the appropriate completed athletic and health service forms on file and full clearance from the College of Saint Elizabeth athletic director, you will not be allowed to participate in practice or competition. Only College of Saint Elizabeth original forms will be accepted.

Information about Athletic Injuries

Whenever a student is injured in a particular sport and requires a physician’s note, she shall not be permitted to practice or take part in athletics until she has received a release from the attending physician. This release must be placed on file in the Health Office and in the Athletic Director’s Office. The athletic trainer/athletic director must be notified of any injuries within 24 hours of the injury.
COLLEGE OF SAINT ELIZABETH
ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the student and reviewed by the physician
Part B: PHYSICAL EVALUATION FORM-Completed by the physician
(You must ALSO complete the Traditional Undergraduate health history, physical and immunization requirement forms)

Part A: HEALTH HISTORY QUESTIONNAIRE
Today's Date: ____________ Student's Name: ____________________________ Sex: M F (circle one)
Age: ______ Date of Birth: __/__/____ Home Phone: (____) ____________ Cell Phone: (____) ____________
Sport(s): __________________________
Physician Name/ Address _______________________________________________________________
Physician Phone: __________________________ Fax ________________________________

Directions: Please answer the following questions about the student's medical history by CIRCLING the correct response.
Explain all "yes" responses on the lines below the questions. Please respond to all questions.

1. Have you ever had or do you currently have:
   a. Restriction from sports for a health related problem? Y / N / Don't Know
   b. An injury or illness since your last exam? Y / N / Don't Know
   c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know
      (1) An inhaler or other prescription medicine to control asthma? Y / N / Don't Know
   d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know
   e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
   f. Any allergies to medications? Y / N / Don't Know
   g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't Know
      (1.) If yes, check type of reaction:
         □ Rash □ Hives □ Breathing or other anaphylactic reaction Y / N / Don't Know
      (2.) Take any medication/Epipen taken for allergy symptoms? (List below)
   h. Any anemia's, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know
   i. Enlarged spleen? Y / N / Don't Know
   j. A blood relative who died before age 50? Y / N / Don't Know
   k. Any illicit drugs, alcohol, tobacco usage, chewing tobacco, snuff, or dip? Y / N / Don't Know
   l. Groin pain or painful bulge or hemia in the groin area? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

List all medications here:
Medication Name Dosage Frequency (Prescription and non-prescription include supplements, vitamins and performance enhancers)
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Rev. 10-4-2016 Adapted from NJ Dept. of Education
2. Have you ever had, or do you currently have, any of the following head-related conditions:
   a. Concussion or head injury (including "bell rung" or a "ding")? Y / N / Don't Know
   b. Memory loss? Y / N / Don't Know
   c. Knocked out? Y / N / Don't Know
   d. Hit or blow to the head that caused confusion, prolonged headache. Or memory problems? Y / N / Don't Know
   e. Unable to move your arms or legs after being hit or falling? Y / N / Don't Know
   f. A seizure? Y / N / Don't Know
   g. Frequent or severe headaches (With or without exercise)? Y / N / Don't Know
   h. Fuzzy or blurry vision Y / N / Don't Know
   i. Sensitivity to light/noise Y / N / Don't Know
   j. Anyone in the family with unexplained fainting, unexplained seizures, or near drowning? Y / N / Don't Know

   Explain all "yes" answers here (include relevant dates):

3. Have you ever had, or do you currently have, any of the following heart-related conditions:
   a. Restriction from sports for heart problems? Y / N / Don't Know
   b. Chest pain or discomfort? Y / N / Don't Know
   c. Heart murmur? Y / N / Don't Know
   d. High blood pressure? Y / N / Don't Know
   e. Elevated cholesterol level? Y / N / Don't Know
   f. Racing or skipped heartbeats? Y / N / Don't Know
   g. Unexplained difficulty breathing or fatigue during exercise? Y / N / Don't Know
   h. Any family member (blood relative):
      1. Under age 50 with a heart condition? Y / N / Don't Know
      2. With Marfan Syndrome? Kawasaki Disease? Brugada syndrome? Y / N / Don't Know
      3. With a heart murmur? Y / N / Don't Know
      4. Arrhythmogenic right ventricular cardiomyopathy? Long QT syndrome? Short QT syndrome? Y / N / Don't Know
      5. Hypertrophic cardiomyopathy? Y / N / Don't Know
      6. Catecholaminergic polymorphic ventricular tachycardia? Y / N / Don't Know
      7. Have a heart problem, pacemaker, or implanted defibrillator? Y / N / Don't Know
      8. Died of a heart problem before age 50? If yes, at what age? Y / N / Don't Know
      9. Died with no known reason? Y / N / Don't Know
      10. Died while exercising? If yes, was it during or after? (Circle one.) Y / N / Don't Know

   Explain all "yes" answers here (include relevant dates):

4. Have you ever had, or do you currently have, any of the following eye, ear, nose, mouth or throat conditions:
   a. Vision problems?
      1. Wear contacts, eyeglasses or protective eye wear? (Circle which type.) Y / N / Don't Know
      2. Eye Injury? Y / N / Don't Know
   b. Hearing loss or problems?
      1. Wear hearing aides or implants? Y / N / Don't Know
   c. Nasal fractures or frequent nose bleeds? Y / N / Don't Know
   d. Wear braces, retainer, protective mouth gear, face shield? Y / N / Don't Know
   e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? Y / N / Don't Know

   Explain all "yes" answers here (include relevant dates):
5. Have you ever had, or do you currently have, any of the following neuromuscular/orthopedic conditions:
   a. Injury to bone, muscle, ligament, or tendon that caused you to miss a practice or a game?  Y / N / Don’t Know  
   b. Numbness, a “burner”, “stinger” or pinched nerve?  Y / N / Don’t Know  
   c. A sprain? a strain?  Y / N / Don’t Know  
   d. Dislocated joint(s)?  Y / N / Don’t Know  
   e. Upper or lower back pain?  Y / N / Don’t Know  
   f. Fracture(s), stress fracture(s), or broken bone(s)?  Y / N / Don’t Know  
   g. Swelling, pain, redness, warmth of muscles, tendons, bones or joints?  Y / N / Don’t Know  
   h. Bone, muscle or joint injury that bothers you?  Y / N / Don’t Know  
   i. History of juvenile arthritis or connective tissue disease?  Y / N / Don’t Know  
   j. Do you wear any protective braces, orthotics, equipment or other assistive devices?  Y / N / Don’t Know  
   k. Neck instability or atlantoaxial instability? (Down Syndrome or dwarfism)  Y / N / Don’t Know  

Explain all (yes) answers here (include relevant dates):

6. Have you ever had or do you currently have any of the following general or exercise related conditions:
   a. Difficulty breathing?
      (1.) During exercise?  Y / N / Don’t Know  
      (2.) After running one mile?  Y / N / Don’t Know  
      (3.) Coughing, wheezing or shortness of breathe in weather changes?  Y / N / Don’t Know  
      (4.) Exercise-induced asthma?
         i. Controlled with medication? (specify __________________)  Y / N / Don’t Know  
   b. Family history of asthma  Y / N / Don’t Know  
   c. Experience dizziness, passing out or fainting?  Y / N / Don’t Know  
   d. Viral infections (e.g. mono, hepatitis, Coxsackie virus)?  Y / N / Don’t Know  
   e. Become tired more quickly than others?  Y / N / Don’t Know  
   f. Any of the following skin conditions:
      (1.) Rashes, cold sores, herpes, impetigo, MRSA, ringworm, warts?  Y / N / Don’t Know  
      (2.) Sun sensitivity?  Y / N / Don’t Know  
   g. Weight gain/loss (of 10 pounds or more)?  Y / N / Don’t Know  
      (1.) Do you want to weigh more or less than you do now?  Y / N / Don’t Know  
   h. Are you on special diet or do you avoid certain types of foods?  Y / N / Don’t Know  
   i. Eating disorders?  Y / N / Don’t Know  
   j. Taken anabolic steroids or used any other performance supplement?  Y / N / Don’t Know  
   k. Taken any supplements to help you gain or lose weight or improve your performance?  Y / N / Don’t Know  
   k. Heat-related problems (dehydration, dizziness, fatigue, headache)?
      (1.) Heat exhaustion (cool, clammy, damp skin)?  Y / N / Don’t Know  
      (2.) Heat stroke (hot, red, dry skin)?  Y / N / Don’t Know  
      (3.) Muscle cramps?  Y / N / Don’t Know  
   l. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)?  Y / N / Don’t Know  

Explain all “yes” answers here (include relevant dates):

Age of onset of menstruation: _____  How many menstrual periods in the last twelve (12) months? _____  
How many periods missed in the last twelve (12) months? _____

STUDENT SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Signature of Student  Date  Parent/Guardian for Student under 18 years old  Date
ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

THE COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE PHYSICIAN AT THE TIME OF THE MEDICAL EXAM.

Part B: Physical Evaluation Form (Completed by the physician)

STUDENT INFORMATION

Student’s Name: ______________________ Sport(s): ______________________

Sex: M F (circle one) Age: ______ Date of Birth: ______________________

Address: __________________________________________________________

City/State/Zip: __________________________________ Home Phone: __________

Parent/Guardian’s Full Name: ______________________________________

EXAMINING PHYSICIAN CONTACT INFORMATION

Name: ___________________________________ Phone: ___________________

Fax: ___________________________________ City/State/Zip: ______________

FINDINGS OF PHYSICAL EVALUATION


Vision: R 20/____  L 20/____  Corrected: Y / N  Contacts: Y / N  Glasses: Y / N

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>NORMAL?</th>
<th>ABNORMAL FINDINGS - COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td></td>
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<tr>
<td>Head/Neck</td>
<td></td>
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<td>Eyes/Sclera/Pupils</td>
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<td>Ears</td>
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<td>Gross Hearing</td>
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<td>Nose/Mouth/Throat</td>
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<td>Lymph Glands</td>
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<td>Cardiovascular</td>
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<td>Heart Rate</td>
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<tr>
<td>Rhythm</td>
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<tr>
<td>If murmur present</td>
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<tr>
<td>Standing makes it:</td>
<td></td>
<td>Louder  Soft  No Change</td>
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<tr>
<td>Squatting makes it:</td>
<td></td>
<td>Louder  Soft  No Change</td>
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<tr>
<td>Valsalva makes it:</td>
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<td>Louder  Soft  No Change</td>
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<tr>
<td>Femoral Pulses/Radial</td>
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<tr>
<td>Lungs: Auscultation/Percussion</td>
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<td>Chest Contour</td>
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<tr>
<td>Skin</td>
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<td>Abdomen (liver, spleen, masses)</td>
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<tr>
<td>Assessment of physical maturation or Tanner</td>
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<tr>
<td>Scale</td>
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<tr>
<td>Testicular Exam (Males Only)</td>
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<tr>
<td>Neck/Bone/Spine:</td>
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<tr>
<td>Range of Motion</td>
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<td>Scoliosis</td>
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<tr>
<td>Upper Extremities: (ROM, Strength, Stability)</td>
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<tr>
<td>Lower Extremities: (ROM, Strength, Stability)</td>
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<tr>
<td>Neurological: Balance &amp; Coordination</td>
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<tr>
<td>Hemia</td>
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<tr>
<td>Evidence of Marfan Syndrome</td>
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</tbody>
</table>

Rev. 10-4-2016  Adapted from NJ Dept. of Education  Page 4 of 7
Student's Name: ___________________________ Date of Birth: ______________

LABORATORY TESTS (attach lab copy)
Urine Analysis (required) __________________________
CBC (required) __________________________
EKG (required include copy) __________________________
Sickle Cell Trait Screening (required) __________________________
Additional Labs as indicated __________________________

Last Td or Tdap (m/d/y) __________________________
Most recent immunizations and dates __________________________

Medication Name Dosage Frequency

________________________
________________________
________________________
________________________
________________________

General Diagnosis, Observations and Recommendations:

________________________
________________________
________________________
________________________
________________________
________________________
THE HISTORY PREPARED BY THE STUDENT MUST BE REVIEWED BY THE
PHYSICIAN AT THE TIME OF THE PHYSICAL EXAMINATION.

Student's Name: ___________________________ Date of Birth: ____________

CLEARANCES: (See notes at bottom for conditions requiring attention and for a list of sports by level of contact)

☐ A. Student is cleared for participation in all sports without restriction.

☐ B. Student is withheld clearance for participation in any sport until evaluation / treatment of:

_____________________________________________________________

☐ C. Student is cleared for participation in limited types of sports which exclude the following types of sports

Contact: (CHECK ALL THAT APPLY)

☐ CONTACT/COLLISION ☐ NON-CONTACT/STRENUEOUS
☐ LIMITED CONTACT ☐ NON-CONTACT/NON-STRENUEOUS

Due to: _______________________________________________________

_________________________________________________________________

_________________________________________________________________

HISTORY reviewed and documented significant information to the athlete's history AND STUDENT
EXAMINED BY: Physician's/Provider's Stamp:

Physician ___________________________ Date of Exam ____________

PHYSICIAN’S SIGNATURE: ___________________________ Today's Date: ____________

Address ____________________________________________

Phone________________________ Fax_______________________

NOTES TO THE EXAMINING PROVIDER

Conditions requiring clearance before sports participation include, but are not limited to the following:
Anaphylaxis; 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 athletes; Hepatomegaly; Splenomegaly; Malignancy; Seizure
Disorder; Marfan Syndrome; 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.

<table>
<thead>
<tr>
<th>Contact/Collision</th>
<th>Limited contact</th>
<th>Strenuous</th>
<th>Non-Contact</th>
<th>Non-strenuous</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basketball</td>
<td>Baseball</td>
<td>Discus</td>
<td>Bowling</td>
<td></td>
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<tr>
<td>Diving</td>
<td>Cheerleading</td>
<td>Javelin</td>
<td>Golf</td>
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<tr>
<td>Field Hockey</td>
<td>Fencing</td>
<td>Shot put</td>
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<tr>
<td>Football</td>
<td>High Jump</td>
<td>Rowing</td>
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<tr>
<td>Ice hockey</td>
<td>Pole Vault</td>
<td>Running/Cross Country</td>
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<tr>
<td>Lacrosse</td>
<td>Gymnastics</td>
<td>Strength Training</td>
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<tr>
<td>Soccer</td>
<td>Skiing</td>
<td>Swimming</td>
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<td>Wrestling</td>
<td>Softball</td>
<td>Tennis</td>
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<td></td>
<td>Volleyball</td>
<td>Track</td>
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</tbody>
</table>
Effects of physiologic maneuvers on heart sounds:

Standing
- Increases murmur of HCM
- Decreases murmur of AS, MR
- MVP click occurs earlier in systole

Squatting
- Increases murmur of AS, MR, AI
- Decreases murmur of MCH
- MVP click delayed

Valsalva
- Increases murmur of HCM
- Decreases murmur of AS, MR
- MVP click occurs earlier in systole

Physical Stigmata of Marfan’s Syndrome
- Kyphosis
- High arched palate
- Pectus excavatum
- Arachnodactyly
- Arm span > height 1.05:1 or greater
- Mitral Valve Prolapse
- Aortic Insufficiency
- Myopia
- Lenticular dislocation

HCM = Hypertrophic Cardio Myopathy
AS = Aortic Stenosis
AI = Aortic Insufficiency
MR = Mitral Regurgitation
MVP = Mitral Valve Prolapse