Bedminster School
Registration Package

Attached you will find the Bedminster School Registration Package. Please print package **SINGLE-SIDED** and return via email to kjohnsen@bedminsterschool.org.

- FAQs
- Registration Form (2 pages) REQUIRED
- Release of Records REQUIRED (Gr. 1 through 8)
- ***McKinney-Vento Questionnaire Form*** ***OPTIONAL***
- Universal Child Health Record (2 pages) REQUIRED
- Health History (3 pages) REQUIRED
- Home Language Survey Form REQUIRED

In addition to the attached package, the following documents are needed. You will be contacted to make an appointment to provide originals of these documents.

PARENT / GUARDIAN ID:

- Passport - Driver's License - Military ID

ORIGINAL PROOF OF BIRTH (One of the following options):

- Passport - Birth Certificate

ORIGINAL PROOF(S) OF RESIDENCY (One from each category):

Category A

- Real Estate Tax Bill
- Mortgage
- Lease

Category B

- Utility Bill
- Bank Statement

U.S. BASED PHYSICAL STAMPED BY A U.S. PHYSICIAN

UPDATED IMMUNIZATIONS FROM U.S. PHYSICIAN

BEDMINSTER TOWNSHIP SCHOOL DISTRICT
FAQ'S

Is Bedminster School a "one school district"?
Yes. We are a pre-K through 8 school district and a sending district to Bernards High School, Bernardsville, NJ in the Somerset Hills School District.

What are the school's hours?
School begins at 8:50 a.m. and ends at 3:20 p.m. No student should arrive prior to 8:40 a.m. unless enrolled in an activity that requires them to be here prior to the start of school, or unless they are enrolled in the before-care program. No student shall stay on premises after the close of school unless participating in one of our after-school activities or enrolled in the after-care program.

Do you have a before care and after care program?
At this time, there is no before care. After care is running at the school and is provided by the Somerset Hills YMCA. Please go on to the website and click on "information" and "child care" to get more information about the program.

Will my child receive busing?
All students that reside in the Township of Bedminster will receive courtesy busing.

How does busing work with the grade differentials within the school?
Bedminster School prides itself in the management of our age differences. Along those lines, we assign seats on our buses, whereby the Kindergarteners are close to the front and the older children sit towards the back. We do not have monitors that ride the bus with the students, but we do have monitors that take attendance each day for our students in grades K through 4, as well as enforce the seat assignments.

Does my child have to ride the bus?
No. We have options for after-care and parent pick up. You may set up a permanent arrangement for the year in writing with our reception desk, or occasionally change your child's destination on a one-time basis in writing by 2:00 p.m. Please refer to the arrival and dismissal procedures listed on our website under "Information" and the "Parent Verification Related Documents".

Does my child have to bring lunch every day?
No. We have a cafeteria with hot lunch and sandwiches that your child may utilize. You may either send them with money or set up an account for your child that can be reloaded throughout the school year. At this time, all children may get lunch free of charge as per the government. This includes the components of a nutritious lunch. Snacks still require payment.

May we set up a tour of Bedminster School?
Tours during the year are not available. As a new student or Kindergartener registering during the summer, you and your child will be able to see the facility at orientation in September just prior to the start of the school year.

BEDMINSTER TOWNSHIP SCHOOL DISTRICT

STUDENT REGISTRATION FORM (Please print & complete ALL sections)

STUDENT INFORMATION

Student Name: _____ (*First* / *Middle* / *Last*) **Date of Birth:** _____ **School Year / Grade:** _____

City, State and Country of birth: _____ (*City* / *State* / *Country*)

Student Birth Name (if different from current name): _____

Student Home Phone Number: _____

Student Physical Address, City, State and Zip Code: _____ (*Street Address* / *City* / *State / Zip Code*)

Student Mailing Address, City, State and Zip Code:
(If different from physical address) _____ (*Address* / *City* / *State / Zip Code*)

Ethnicity (if multi-racial, please circle all that apply): *Hispanic* *African American* *White* *Asian* *Pacific Islander / Native Hawaiian* *American Indian / Native Alaskan*

Gender (please circle one): *MALE* *FEMALE* **Student Birth Gender (if different from current gender):** *MALE* *FEMALE*

If country of birth is NOT the United States: Date of Entry into the United States: _____
Date of First Entry into U.S. School: _____

Primary language spoken at home: _____ **Native Language:** _____

Does student have health insurance? (*Please circle one*): NO YES **If yes, list insurance provider:** _____

Is student's parent/guardian on Active Military Duty, in the National Guard or the Reserve Component of the United States military services? NO YES

PARENT/GUARDIAN INFORMATION

Circle Resident Parent/Guardian: Mother Father Both

Is custody of this child limited by court order or legal agreement? NO YES

IF YES - THE ORIGINAL LEGAL DOCUMENT DECLARING RESIDENTIAL CUSTODY MUST BE PROVIDED TO THE SCHOOL UPON REGISTRATION

MOTHER INFORMATION: ***NAME:*** _____

Address, City, State and Zip Code: _____ (*Street Address* / *City* / *State / Zip Code*)

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

E-mail address: _____

FATHER INFORMATION: ***NAME:*** _____

Address, City, State and Zip Code: _____ (*Street Address* / *City* / *State / Zip Code*)

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

E-mail address: _____

(OVER)

EMERGENCY CONTACT & SIBLING INFORMATION

Contact #1 NAME: _____ RELATIONSHIP: _____

PHONE: _____ CELL: _____ WORK: _____

Contact #2 NAME: _____ RELATIONSHIP: _____

PHONE: _____ CELL: _____ WORK: _____

Contact #3 NAME: _____ RELATIONSHIP: _____

PHONE: _____ CELL: _____ WORK: _____

Contact #4 NAME: _____ RELATIONSHIP: _____

PHONE: _____ CELL: _____ WORK: _____

SIBLING INFORMATION:

1) NAME: _____ AGE: _____

2) NAME: _____ AGE: _____

3) NAME: _____ AGE: _____

4) NAME: _____ AGE: _____

SPECIAL PROGRAMS

Has your child ever been in a Special Needs Program? NO YES **Is your child currently in a Special Needs Program?** NO YES

Please circle all types of programs that apply: 504 I & RS IEP

Is your child receiving Speech Services? NO YES

Has your child ever been in or are they currently in a Limited English Proficiency/English as a Second Language (ESL) Program? NO YES

PLEASE BE SURE TO SIGN AND DATE

PARENT / GUARDIAN SIGNATURE: _____

DATE: _____

REVISED: 1/2021

BEDMINSTER TOWNSHIP PUBLIC SCHOOL DISTRICT
234 Somerville Road
Bedminster, New Jersey 07921
Telephone (908) 234-0768 Fax (908) 234-2318
www.bedminsterschool.org

REQUEST FOR STUDENT RECORDS

NAME & ADDRESS OF PREVIOUS SCHOOL

NAME: _____

ADDRESS: _____

_____

FAX #: _____

STUDENT NAME	GRADE	BIRTHDATE
_____	_____	_____
_____	_____	_____

(Please Print)

The above named pupil has recently enrolled in our school. **Please send all academic, health & CST records to:**

BEDMINSTER TOWNSHIP SCHOOL
234 SOMERVILLE ROAD
BEDMINSTER, NJ 07921
ATTENTION: SCHOOL SECRETARY

I do hereby authorize the release of academic/health/CST records regarding the above named pupil to the Bedminster Township School.

_____ _____

Parent/Guardian Signature Date

Bedminster Township School

234 Somerville Road, Bedminster, NJ 07921
908-234-0768

Home Language Survey

Student name: _____ Student birth date: _____

Student address: _____

Student Phone number: _____

Question 1: What was the first language used by the student? _____

Question 2: At home, does the student hear or use a language other than English more than half of the time?
Circle one: Yes No

Question 3: Does the student understand a language other than English?
Circle one: Yes No

Question 4: When interacting with his/her parents or guardians, does the student use a language other than English more than half of the time?
Circle one: Yes No

Question 5: When interacting with caregivers other than their parents or guardians, does the student use a language other than English more than half of the time?
Circle one: Yes No

Question 6: Has the student recently moved from another school district/charter school where he/she was identified as an English language learner?
Circle one: Yes No

If "yes" is answer for questions 2,3,4,5 or 6, indicate student's home language to finish survey:

_____

_____ _____

Parent/Guardian Signature Date

MCKINNEY-VENTO QUESTIONNAIRE FORM
(OPTIONAL & CONFIDENTIAL)
Bedminster Township School

Student Name: _____ Date of Birth: _____

School Name: _____ Grade: _____

Your child may be eligible for additional educational services through the McKinney-Vento Homeless Assistance Act. Eligibility can be determined by completing this questionnaire. **THE INFORMATION YOU PROVIDE IS CONFIDENTIAL.** If eligible, students are to be immediately enrolled in accordance with the McKinney-Vento Assistance Act.

1. **Do you/your student live in any of these following situations?**
   - ☐ In emergency or transitional shelter or program
   - ☐ Sharing the housing of other persons due to:
     - ☐ Loss of housing, economic hardship or a similar reason (i.e. evicted)
     - ☐ Long term, cooperative living arrangement
     - ☐ Other (please specify): _____
   - ☐ In a vehicle of any kind, park, public space, abandoned building, substandard housing, bus or train station or similar setting
   - ☐ In a motel, hotel, campground or similar setting due to: (select one)
     - ☐ Lack of alternative adequate accommodations
     - ☐ A convenient living arrangement (i.e. waiting for apartment/home to be ready)
     - ☐ Other (please specify): _____
   - ☐ None of the above

2. **What is your/your student's living situation?** Please check one box.
   - ☐ Living with your legal parent guardian
   - ☐ Living alone
   - ☐ Living with an adult that is not a legal parent or guardian

---

The undersigned certifies that the information provided is accurate:

PRINT NAME OF PERSON COMPLETING FORM: _____

SIGNATURE: _____

DATE: _____

ADDRESS OF CURRENT RESIDENCE: _____

_____

PHONE NUMBER OR MESSAGE NUMBER: _____

Bedminster Township School
Health History

Child's Full Name:

_____

(Last) (First) (Middle) (Nickname)

_____ _____ Grade_____

(Date of Birth) (Country of Birth)

Please complete the following health history. **Give dates,** if possible.
Has your child ever had the following? **If yes, please explain:**

1. Accident(s) _____
2. Allergic Reactions (Include bee stings, food or medications, etc.)
Yes_____ No_____ **If yes, explain** _____
_____
Has your child ever needed medication or medical attention in the past for a reaction to a bee sting or food allergy? Yes_____ No_____ **If yes, please provide details:** _____
_____
3. Asthma Attack: Yes_____ No_____ Other Respiratory Infections: Yes_____ No_____
Explain _____
4. Bone or Joint Disease or Injury: Yes_____ No_____ **If yes, explain** _____
_____
5. Communicable Diseases (Specify): _____
6. Convulsion or Seizures: Yes_____ No _____ **If yes, explain** _____
_____
7. Diabetes: _____
8. Dental Problems: Yes____ No_____ Explain_____
9. Ear Infections: Yes _____ No _____ Ear Tubes: Yes _____ No _____ Date _____

Does your child have a hearing problem? Yes _____ No _____
Does your child wear a hearing aide? Yes _____ No _____
Does your child have a speech/language problem? Yes _____ No _____

10. Frequent throat infections: Yes _____ No _____
11. Frequent headaches: Yes _____ No _____
12. Kidney or Urinary Tract Problems: Yes_____ No _____**Explain if yes** _____
_____
13. Heart Problems/Murmurs/Rheumatic Fever: Yes _____ No _____ **Explain** _____
_____
14. Does your child have any vision problems: Yes _____ No _____
15. Does your child wear glasses? Yes_____(when) _____No_____

16. Does your child have any neuromuscular problems or limitations? Yes_____ No _____
Explain if yes _____
17. Does your child have any developmental delays or been diagnosed with any syndromes?
Yes_____ No_____ **Explain if yes** _____
18. Has your child ever been hospitalized? Yes _____ No _____ **If yes, state when and reason:** _____
19. What medicine, if any, does your child take? _____
_____
20. Does your child have any present physical limitations that may require program modifications or restrictions? _____
_____
21. Please add any other problems or comments you would like to bring to the attention of the school nurse: _____
_____

Note: **No Medication can be given at school without a completed medication administration form signed by the parent and the prescribing physician. All medication must be in the original container with the pharmacy label intact. Medications should be hand delivered to the school nurse by the parent or guardian. Please see the school nurse or the school website for medication administration forms.**

Parent's Signature _____ Date_____
Mother's Full Name _____ Employer _____
Home Address _____ Work Address _____
_____ _____
Home Phone_____ Work Phone _____
Cell Phone _____
Father's Full Name _____ Employer _____
Home Address _____ Work Address _____
_____ _____
Home Phone _____ Work Phone _____
Cell Phone _____

Home Situation:

_____ Parents reside together
_____ Parents separated
_____ Parents divorced
_____ Guardian cares for child
_____ Single parent home
_____ Father remarried
_____ Mother remarried
_____ Other _____

If parents are divorced or separated, who has legal (official) custody? _____

**Legal custody papers should be supplied to the Main Office and stored in child's Permanent Record Folder.

Child's Name: _____
Name and age of sibling(s): _____
_____

Last school attended_____address:_____
Describe child's last school experience:
_____
_____
Was child absent frequently? If so, explain _____
_____

Personality and Emotional Development
Please check all that apply to your child:

_____Happy	_____Moody	_____Withdrawn
_____Sad	_____Easily upset	_____ Overactive
_____Friendly	_____Quiet	

Problems when separated from family? Yes _____ No _____ Explain: _____
_____
Loss of family member? Yes _____ No _____ Explain: _____
_____

Social Interactions
(Please check where appropriate)

Peers	Adults
_____Good	_____ Good
_____Fair	_____Fair
_____Poor	_____ Poor

Traumatic events? If so, please explain: Yes _____ No _____ explain: _____
_____
_____

Please list any concerns, questions or problems that the school personnel should know about
_____
_____

Please sign below if you would like **this page** shared with your child's teacher (if needed).
Parent's Signature _____

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 _____

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

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 _____

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 _____

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