Cedar Grove Public Schools

Michael J. Fetherman, Superintendent

520 Pompton Ave. Cedar Grove, New Jersey 07009
(973) 239-1550 www.cedargrove.k12.nj.us

PRIOR TO ENTERING CEDAR GROVE MEMORIAL MIDDLE SCHOOL, THE FOLLOWING CONDITIONS MUST BE SATISFIED:

Transfer student must be signed out of previous school with the following:

- Birth Certificate
- Transfer Card
- Copy of Transcript
- Copy of Schedule
- Copy of Report Card
- Immunization (A-45) Health Records (copy is acceptable)

The following residency documents are required for registration:

- Homeowners - one of the following from List A and any three (3) from List B:

  List A

  - ❑ Current mortgage statement
  - ❑ Property tax bill
  - ❑ Deed

  List B (All bills must be current)

  - ❑ Phone bill
  - ❑ Cable bill
  - ❑ Electricity bill
  - ❑ Water bill
  - ❑ Insurance bill
  - ❑ Bank account statement
  - ❑ Credit card statement

- Renters - both of the following and any three (3) from List B above:
  - ❑ Lease
  - ❑ Landlord affidavit

Thank you for your anticipated cooperation. Please contact the Registration Office at (973) 239-1550 x 6200 if you have any questions.

Cedar Grove Public Schools
Administrative Office
520 Pompton Ave.
Cedar Grove, NJ 07009
973-239-1550
www.cedargrove.k12.nj.us

Student Registration Information

Name of Student _____ School _____ Grade _____

Date of Birth _____ Sex _____ SID # _____

Address _____ Home Telephone # _____

Fathers Name	Occupation	Work Telephone #
Fathers address if different from above		Fathers Cell #
Mothers Name	Occupation	Work Telephone #
Mothers address if different from above		Mothers Cell #
E-mail address (This is the primary e-mail contact)		

Country of Birth	City and State of birth
Born outside the U.S. Date of entry to U.S.	Country of Citizenship

What is the primary language spoken at home: _____ Is student proficient in English _____

Is the student proficient is any language other than English _____

Race: White _____ Black _____ Hispanic _____ AsianPacific Islander or Native Hawaiian _____

American Indian/Alaskan _____ Other _____ (Please specify) _____

Please check all that apply:

_____ I am the natural parent

_____ The student being registered is living with <u>both</u> natural parents

_____ The student is residing with natural mother or father (please circle one)

_____ Mother/Father has: ___sole legal custody* ___joint legal custody* ___joint physical custody*
(circle one)

_____ I am the step-parent _____ I am the legal guardian*

***A copy of the legal document is required for the student's file**

<u>Educational History</u>

Last School Attended: _____

Address: _____

Dates Attended: _____

Does your child have an IEP (Individual Educational Plan) _____

504 Plan _____ ISP (Individual Support Plan) _____

Has your child received any of the following services? (please circle)

BSI(comp. ed) ESL classes Bilingual classes

Related Services: Speech Occupational Therapy Physical Therapy

_____ _____

Signature of person registering student Date

(Office use only)

The following was received at time of registration:

Birth Certificate _____ Passport _____ F1Visa _____

<u>Primary Proof of Residency:</u>

Deed _____ Tax bill _____ Lease agreement _____ Mortgage statement _____

<u>Secondary Proof of Residency</u>: Current Bill or Statement _____

<u>ALL proof must be in the name of person registering student and must be current. No Exceptions.</u>

_____ Staff member that received documentation

FOR RENTERS ONLY

CEDAR GROVE SCHOOL DISTRICT
LANDLORD AFFIDAVIT

STATE OF NEW JERSEY :
: SS
COUNTY OF _____ :

I, _____ do swear under oath to the following:

1. (Check A or B below)

   (A) I am the owner of the dwelling unit located at _____,
   (street and/or apartment unit address)

   Cedar Grove, Essex County, New Jersey.

   (B) I am _____ of _____
   (name of landlord corporation/partnership)

   the owner of the dwelling unit located at _____,
   (street and/or apartment unit address)

   Cedar Grove, Essex County, New Jersey.

2. _____ is a tenant residing in the dwelling unit under an
   (name of tenant)

   unwritten lease.

3. I am making this Affidavit in connection with the Tenant's claim that

   _____ is residing with him/her in the dwelling unit and
   (name of student)

   that this student is entitled to a free public education in the Cedar Grove School District.

4. I understand that the Cedar Grove School District will rely upon the statements contained herein to permit the aforenamed student to attend school in the Cedar Grove School District.

5. I certify that the statements contained in this affidavit are true, accurate, and complete. I am aware that if any of the foregoing statements are willfully false, I may be liable for criminal and/or civil penalties.

Sworn to and subscribed :
before me this _____ day :
of _____, 20____ :

_____
Signature of Person Attesting

_____
Notary Public of the State of New Jersey

Emergency Information Verification Form

Please sign as indicated. Also, please fill in any missing information and make corrections where necessary.

Current School:	Grade:	Homeroom:
Student's Name:	DOB:	Sex:

Residence:	Student Cell:	Mailing Address if different than residence:
	Student Email:	Court Orders/Legal Restrictions:

Please include company name for Work numbers, so that if your company changes phone numbers we will still be able to locate you. Emergency numbers will only be used in the event that we cannot reach at the other numbers listed. The Primary or Home Number will also be used for attendance auto-dialer.

Guardian:		Primary #:	E-Mail:
Home:	Cell:	Work: x	Work Cell:
Guardian:		Primary #:	E-Mail:
Home:	Cell:	Work: x	Work Cell:
Emergency 1:		Allowed to be picked up by contact? Y/N	
Home:	Cell:	Work: x	Work Cell:
Emergency 2:		Allowed to be picked up by contact? Y/N	
Home:	Cell:	Work: x	Work Cell:
Emergency 3:		Allowed to be picked up by contact? Y/N	
Home:	Cell:	Work: x	Work Cell:

Health Information:

Medical alerts/allergies
Does your child require a EpiPen?
If yes please provide doctors' orders and EpiPen.
Does your child have asthma?
If yes please provide asthma action plan.
Receives daily medication during school hours (Y/N
Wears glasses and/or contact lenses (Y/N):

This student's health information may be shared with pertinent school staff if necessary to maintain well being and safety.

Parent/Guardian will call the school if student will be absent or late.

_____
Signature **Date**

Health care provider information (for emergency treatment when we are unable to contact you):

Contact Type	Contact Name	Contact Number
Hospital		
Doctor		
Dentist		

Please sign here to indicate that we have your permission to call the physicians listed or to have your child taken to the hospital when you are not available or in an emergency.

_____
Signature **Date**

Does this child have any health insurance including NJ FamilyCare/Medicaid, Medicare, private or other?

☐ **NO** My child **does not** have health insurance. 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).*

NJ FamilyCare provides free or low cost health insurance for uninsured children and certain low income parents. For more information visit www.njfamilycare.org to apply online or call 1-800-701-0710.

☐ **YES** My child has health insurance. If yes, what is the name of the Insurance Company?

Residence:	Student ID: Date Filed: Intials:

CEDAR GROVE PUBLIC SCHOOLS
520 Pompton Avenue
Cedar Grove, NJ 07009
www.cedargrove.k12.nj.us

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL STUDENT INFORMATION

Student's Name _____

Current Grade _____ Date of Birth _____

To: (name of agency or individual) _____

Address: _____

Telephone/Fax: _____

Please release to the Cedar Grove School district the following information

_____ Permanent File
_____ Transfer Card
_____ Educational Records
_____ Special Education Records (all child study team records including medical requests)
_____ Standardized Test Results
_____ Teachers Grades
_____ Health Records

Parent/Guardian Signature _____ Date _____

Please send all of the above records to the school circled below

North End School
122 Stevens Avenue
Cedar Grove, NJ 07009
973-256-1454

South End School
116 Harper Terrace
Cedar Grove, NJ 07009
973-239-2116

Memorial Middle School
500 Ridge Road
Cedar Grove, NJ 07009
973-239-2646

Cedar Grove High School
90 Rugby Road
Cedar Grove, NJ 07009
973-239-6400

Cedar Grove Public Schools
Department of Special Services
520 Pompton Avenue
Cedar Grove, NJ 07009
973-239-1550

Memorial Middle School
Reminders from the School Nurse

Nurse: Julia Lindt
Phone: 973.239.2646 ext. 2005
Email: julia.lindt@CGSchools.org
Hours: 8:45am-2:50pm school days

My mission is to keep our students healthy, in class, and prepared to learn. Please feel welcome to come to the nurse's office and speak with me about your child's health needs during his or her school day.

Remind your child to be careful around the lockers. A major goal for this school year is to decrease the number of hand and head injuries which occur at lockers.

Water bottles: A note from the student's health care provider is required for a student to carry a water bottle to class. The nurse has been delegated to collect these notes.

There is no breakfast program at school and no food until lunch time. If your child refuses to eat breakfast or is running late please send a snack. Juice, crackers, or granola bars are helpful.

Physician notes may be scanned and sent to the school nurse as an email attachment.

Medication at School: Prescription and over-the-counter medications must have a written physician order and a written parental consent for the nurse to administer medication to students. This is the policy of Cedar Grove School District and state law in New Jersey. Please plan to see the nurse when you bring the medication to school; do not leave medication with school staff. All medication must be sent home with an adult at the end of the school year. (Epi Pens and inhalers may be sent home with the student if the student has permission to self administer their own emergency medication.)

Please keep emergency contact information current and update this information with the school office staff if there are any changes.

Parents will find most health forms, including medication forms, on the nurse's Homework Now page called, "forms." There is also a "parent page" with information for parents.

Parents registering students New-to-the-District:

1. Please come to see the school nurse.
2. The student must have an immunization form to register for school.
3. Students have 30 days to bring a physical exam form to the school nurse. The physical exam must be completed by the physician within the previous 365 days of enrolling at the school.

Physical exams are recommended for eighth grade students. The form is on Homework Now.

All students are screened for growth and blood pressure. The sixth and eighth grade students also have scoliosis and vision screening. Seventh grade students have hearing screening. Parents will be notified if a student's screening result falls outside a typical range.

Please encourage students to wear their glasses at school.

If your child receives immunizations at check-up please send the nurse a note from the physician's office.

Please call the main office before 9:00am if you child will be absent at 973-239-2646.

New Jersey Department of Health
Vaccine Preventable Disease Program

STUDENTS WITHOUT AN IMMUNIZATION RECORD

Student is new and has never attended school before?

YES

Student is transferring from another school within NJ?

YES

DO NOT ENROLL STUDENT until an immunization record is provided.

Student is transferring from out of state or out of country?

YES

30 DAY GRACE PERIOD

The student shall be admitted temporarily for up to 30 days if acceptable evidence of vaccination is not available. If after the 30 days have elapsed and no documentation of previous vaccination is provided, the child may not attend school until one dose of all age-appropriate required vaccines are received before being provisionally admitted and must be on schedule to receive subsequent doses as rapidly as medically feasible.

Once the student's immunization record is obtained, follow the "STUDENTS WITH AN IMMUNIZATION RECORD" Flow Chart.

NJ Department of Health
Vaccine Preventable Disease Program

New Jersey Minimum Immunization Requirements for Kindergarten-Grade 12 Attendance
N.J.A.C. 8:57-4 Immunization of Pupils in School

Guide for checking compliance
Step 1: Each child attending/enrolling must present documentation of immunizations or valid medical or religious exemption to vaccines. In order to allow a child to enter school, he/she must have at least one dose of each age-appropriate required vaccine.
Step 2: Determine child's present grade level.
Step 3: Compare the child's record with the requirements listed on the chart below.

Grade/level child enters school:		Minimum Number of Doses for Each Vaccine						
		DTaP Diphtheria, Tetanus, acellular Pertussis	**Polio Inactivated Polio Vaccine (IPV)**	**MMR (Measles, Mumps, Rubella)**	**Varicella (Chickenpox)**	**Hepatitis B**	**Meningococcal**	**Tdap (Tetanus, diphtheria, acellular pertussis)**
Kindergarten – 1st grade		A total of 4 doses with one of these doses on or after the 4th birthday OR any 5 doses*	A total of 3 doses with one of these doses given on or after the 4th birthday OR any 4 doses*	2 doses†	1 dose	3 doses	None	None
2nd – 5th grade		3 doses *NOTE: Children 7 years of age and older, who have not been previously vaccinated with the primary DTaP series, should receive 3 doses of Tetanus, diphtheria (Td)*	3 doses	2 doses	1 dose	3 doses	None	None
6th grade and higher		3 doses	3 doses	2 doses	1 dose required for children born on or after 1/1/98§	3 doses¶	1 dose required for children born on or after 1/1/97 given no earlier than ten years of age**	1 dose required for children born on or after 1/1/97 **

Additional vaccines are recommended by the Centers for Disease Control and Prevention (CDC). The chart above lists only the vaccines that are required for school attendance in NJ. Please note that unvaccinated children, including those with medical and/or religious exemptions, may be excluded from school during a vaccine preventable disease outbreak or threatened outbreak to ensure public health safety.

For the complete CDC Recommended Immunization Schedule, please visit http://www.cdc.gov/vaccines/schedules/index.html.

* **DTaP:** Children who previously attended child care/preschool should have received 4 doses since the requirement to receive the fourth birthday booster dose (5th dose) does not apply until the child attends Kindergarten. However, if one of these 4 doses was given after the 4th birthday, this child will not need an additional dose for Kindergarten. Children will need 5 doses if all doses were administered prior to the 4th birthday in order to enter Kindergarten.

Polio: Children who previously attended child care/preschool should have 3 doses since the requirement to receive the fourth birthday booster dose (4th dose) does not apply until the child attends Kindergarten. However, if one of these 3 doses was given after the 4th birthday, this child will not need an additional dose for Kindergarten.

Children will need 4 doses if all doses were administered prior to the 4th birthday.

† A child is required to receive two doses of measles, one dose of mumps, and one dose of rubella once he/she enters Kindergarten. Since single antigen (separate components of the vaccine) is not readily available, most children will have two MMR vaccines.

The Antibody Titer Law (Holly's Law, NJSA 26:2N-8-11), passed on January 14, 2004, requires the New Jersey Department of Health (NJDOH) to accept serologic evidence of protective immunity to measles, mumps and rubella in lieu of the second ACIP recommended measles, mumps and rubella vaccine. For more information, please visit http://nj.gov/health/cd/documents/antibody_titer_law.pdf.

§ Varicella vaccine is only required for children born on or after January 1, 1998. A child will not have to receive the varicella vaccine if he/she previously had chickenpox as long as a parent can provide the school with one of the following: 1) Documented laboratory evidence showing immunity (protection) from chickenpox, 2) A physician's written statement that the child previously had chickenpox, or 3) A parent's written statement that the child previously had chickenpox.

¶ Two doses of hepatitis B vaccine is acceptable if child received the vaccine between 11 – 15 yrs. of age AND the vaccine is identified as Adolescent Formulation. Children who present documented laboratory evidence of hepatitis B disease or immunity, constituting a medical exemption, shall not be required to receive hepatitis B vaccine.

** Tdap and Meningococcal vaccines are required for all entering 6th graders who are 11 years of age or older; 6th graders < 11 years must receive Tdap and meningococcal vaccines once age 11 is reached.

For the complete list of "NJ Immunization Requirements Frequently Asked Questions", please visit http://nj.gov/health/cd/imm.shtml.

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 keeps 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 _____

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

NOTE: The preparticipation 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* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)†		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic‡		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
†Consider GU exam if in private setting. Having third party present is recommended.
‡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 _____

HC:SS3 9-2681/0410
New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

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