SOUTHERN REGIONAL HIGH SCHOOL DISTRICT
Athletic Department
(609)597-9481

ATHLETIC PERMIT

School Year _____

SEASON: Fall Winter Spring
(Please circle one)

Last Name_____ First _____ I.D. # _____ Sex _____

Grade: _____ Age_____ Sport: _____

Birthdate____/____/____, Birthplace: Town _____ State_____

Home Address: _____
Street Address City State Zip

Home Phone # _____ Parent/Guardian Name _____

Emergency Contact Name _____ Emergency Phone # _____

Transfer in this year? _____ If yes, from what school? _____

- Have you received an athletic physical this school year? NO _____

Yes ____ Sport_____ Dr. Schmoll ____ Home Physician ____

- Have you been injured in any sport this school year? NO _____

Yes _____ Please describe injury:_____

CODE OF CONDUCT:

All student athletes participating in both the high and middle school interscholastic athletic programs are held to the highest standard of character and sportsmanship. The Board of Education has approved Athletic Rules and Regulations that are available on the school website at http://athletics.srsd.net/.

We acknowledge that we have read and reviewed the Athletic Rules and Regulation. We have reviewed and understand the student athlete discipline procedure and do agree to abide by the rules and regulations set herein.

INFORMED CONSENT:
Realizing that such activity involves the potential for injury which is inherent in all sports, I/we acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of the rules, injuries are still a possibility. On rare occasions, these injuries can be so severe as to result in total disability, paralysis, or even death. I/we acknowledge that I give permission for my child to participate in

(Sport): _____ Student Signature _____

Parent Signature _____ Date _____

FOR OFFICE USE ONLY:

revious Sport _____ Physical Date _____ Credits _____

NJSIAA

1161 Route 130, P.O. Box 487, Robbinsville, NJ 08691 609-259-2776 609-259-3047-Fax

NJSIAA STEROID TESTING POLICY

CONSENT TO RANDOM TESTING

In Executive Order 72, issued December 20, 2005, Governor Richard Codey directed the New Jersey Department of Education to work in conjunction with the New Jersey State Interscholastic Athletic Association (NJSIAA) to develop and implement a program of random testing for steroids, of teams and individuals qualifying for championship games.

Beginning in the Fall, 2006 sports season, any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances on the attached page, without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition. The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing.

By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that, if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

SPORT _____

Signature of Student-Athlete	Print Student-Athlete's Name	Date

Signature of Parent/Guardian	Print Parent/Guardian's Name	Date

PLEASE SIGN BOTH SIDES

What Should a Student-Athlete do if they think they have a concussion?

- **Don't hide it.** Tell your Athletic Trainer, Coach, School Nurse, or Parent/Guardian.
- **Report it.** Don't return to competition or practice with symptoms of a concussion or head injury. The sooner you report it, the sooner you may return-to-play.
- **Take time to recover.** If you have a concussion your brain needs time to heal. While your brain is healing you are much more likely to sustain a second concussion. Repeat concussions can cause permanent brain injury.

What can happen if a student-athlete continues to play with a concussion or returns to play to soon?

- Continuing to play with the signs and symptoms of a concussion leaves the student-athlete vulnerable to second impact syndrome.
- Second impact syndrome is when a student-athlete sustains a second concussion while still having symptoms from a previous concussion or head injury.
- Second impact syndrome can lead to severe impairment and even death in extreme cases.

Should there be any temporary academic accommodations made for Student-Athletes who have suffered a concussion?

- To recover cognitive rest is just as important as physical rest. Reading, texting, testing-even watching movies can slow down a student-athletes recovery.
- Stay home from school with minimal mental and social stimulation until all symptoms have resolved.
- Students may need to take rest breaks, spend fewer hours at school, be given extra time to complete assignments, as well as being offered other instructional strategies and classroom accommodations.

Student-Athletes who have sustained a concussion should complete a graduated return-to-play before they may resume competition or practice, according to the following protocol:

- Step 1: Completion of a full day of normal cognitive activities (school day, studying for tests, watching practice, interacting with peers) without reemergence of any signs or symptoms. If no return of symptoms, next day advance.
- Step 2: Light Aerobic exercise, which includes walking, swimming, and stationary cycling, keeping the intensity below 70% maximum heart rate. No resistance training. The objective of this step is increased heart rate.
- Step 3: Sport-specific exercise including skating, and/or running: no head impact activities. The objective of this step is to add movement.
- Step 4: Non contact training drills (e.g. passing drills). Student-athlete may initiate resistance training.
- Step 5: Following medical clearance (consultation between school health care personnel and student-athlete's physician), participation in normal training activities. The objective of this step is to restore confidence and assess functional skills by coaching and medical staff.
- Step 6: Return to play involving normal exertion or game activity.

For further information on Sports-Related Concussions and other Head Injuries, please visit:

www.cdc.gov/concussion/sports/index.html www.nfhs.com
www.ncaa.org/health-safety www.bianj.org www.atsnj.org

Signature of Student-Athlete	Print Student-Athlete's Name	Date
Signature of Parent/Guardian	Print Parent/Guardian's Name	Date

NCAA Eligibility Center

Core Courses offered at Southern Regional High School

The following list of core courses offered at Southern Regional are **approved** for prospective student-athletes seeking NCAA Division I or II initial-eligibility.

English I RR	World History	Algebra 1	Science Seminar	French I
English I	World History Advanced	Algebra I Advanced	Science Seminar II	French II
English I Advanced	World History Honors	Geometry	Geophysical Science	French III
English I Honors	US History RR	Geometry Advanced	Geophysical Science Adv.	French IV Honors
English II RR	US History I	Geometry Honors	Bio-Com	German I
English II	US History I Advanced	Algebra II	Biology	German II
English II Advanced	US History I Honors	Algebra II Advanced	Biology Honors	German III
English II Honors	US History II RR	Algebra II Honors	Chem-Com	German IV Honors
English III RR	US History II	Trig/Pre-Calc.	Chemistry	Japanese I
English III	US History II Advanced	Trig/Pre-Calc. Honors	Chemistry Honors	Japanese II
English III Advanced	US History II AP	Calculus I	Physics	Japanese III
English III Honors	AP Government & Politics	AP Calculus	AP Physics I	Japanese IV Honors
English III AP	AP European History	AP Calculus II	AP Physics II	Latin I
English IV RR	AP Psychology	Algebra III	AP Biology	Latin II
English IV	Critical Issues	AP Statistics	AP Chemistry	Latin III
English IV Advanced			Anatomy/Physiology	Latin IV Honors
English IV Honors			Environmental Science/Marine Biology	Spanish I
English IV AP				Spanish II
Journalism I				Spanish III
Creative Writing				Spanish IV
				AP Spanish Literature

The following list of core courses offered at Southern Regional are **not approved** for prospective student-athletes seeking NCAA Division I or II initial-eligibility.

Essentials of English I	Essentials of World History	Essentials of Algebra 1	Basic Environmental Science / Marine Biology	Spanish for Communication
Essentials of English II	Essentials of US History I	Essentials of Geometry		
Essentials of English III	Essentials of US History II	Essentials of Algebra II		
Essentials of English IV				

Beginning **August 1, 2016**, NCAA Division I will require 10 core courses to be completed prior to the seventh semester (seven of the 10 core courses must be a combination of English, math or natural or physical science). These 10 courses become "locked in" at the seventh semester and cannot be retaken for grade improvement.

Make sure you have your course schedule in order!

I have read and understand the NCAA Eligibility document in this Athletic Permit packet.

_____/_____ _____/_____

Parent/Guardian / date Student Athlete / date

Parents Code of Conduct

We feel that as parents we play a vital role in the development of our student-athletes. Therefore, we believe that we should:

- Be a positive role model through our own actions to make sure our child has the best athletic experience possible.
- Be a "team" fan, not a "my kid" fan.
- Show respect for the opposing players, coaches, spectators, and support groups.
- Be respectful of all officials' decisions.
- Please do not instruct your children before or after a game, because it may conflict with the coach's plans and strategies.
- Praise the student-athletes in their attempt to improve themselves as students, as athletes, and as people.
- Gain an understanding and appreciation for the rules of the contest.
- Recognize and show appreciation for an outstanding play by either team.
- Help our children learn that success is oriented in the development of a skill, and we should make the student-athletes feel good about themselves, win or lose.
- 24 hour rule (not directly after the game). Take time to talk with the coaches in an appropriate manner including proper time and place. Be sure to follow the designated chain of command by scheduling a meeting
- Reinforce the school's drug and alcohol free policies by refraining from the use of any controlled substances before and during athletic contests.
- Remember that a ticket to a school athletic event is a privilege to observe the contest.

SOUTHERN REGIONAL HIGH SCHOOL
Athletic Department
90 Cedar Bridge Road, Manahawkin, NJ 08050
(609)597-9481

MEDICAL PERMIT

Dear Parents:

According to the New Jersey Administrative Code (N.J.A.C. 6A:16-2.2), "each student's medical examination shall be conducted at the medical home of the student" (the student's physician or nurse practitioner/clinical nurse specialist). Since the school physician is a "healthcare provider", the parent/guardian may choose either the school physician or their own private physician to provide medical examination.

This form must be filled out and signed by the parent/guardian, indicating whether the student will be using the school physician or a private physician for the physician. PLEASE ONLY COMPLETE ONE SECTION.

HOME PHYSICIAN:

Student's Name _____ I.D. # _____

Homeroom Teacher _____

Sport _____ Grade _____

Student _____ will receive a physical from our home physician.

Parent's Signature _____ Date _____

SCHOOL PHYSICIAN:

Student's Name _____ I.D. # _____

Homeroom Teacher _____

Sport _____ Grade _____

Student _____ designates the school physician as our home physician for the purpose of an athletic physical.

Parent's Signature _____ Date _____

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 _____

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 _____

PLEASE FILL OUT IF APPLICABLE

SOUTHERN REGIONAL HIGH SCHOOL
Athletic Department
90 Cedar Bridge Road, Manahawkin, NJ 08050
(609)597-9481

SELF-MEDICATION PERMISSION FORM

In accordance with Chapter 308, P.L. 1993, this form must be signed by the parents or guardians of any student who wishes to self-administer medication.

We _____ and _____(print names of parents) are the parents or guardians of _____(print name of student), a student in the Southern Regional School district. As required by law, this form provides to the Southern Regional Board of Education, our written authorization for our child to self-administer medication. We further acknowledge, that by copy of this form, the Southern Regional School board has informed us that the district, its employees or agents, shall incur no liability as a result of any injury from the self-administration of medication boy or child. Further, by signing this form, we release the Southern Regional School Board, its employees and agents, from any liability as a result of any injury from the self-administration of medication by our child, and we expressly agree to defend, protect, indemnify, and hold harmless the Southern Regional School District, and its employees or agents from all losses, costs, suits or claims which may result from the self-administration of medication by our child.

Signature of Parent_____

Date_____ Telephone _____

PHYSICIAN CERTIFICATION FOR SELF-MEDICATION BY STUDENT

In accordance with Chapter 308, P.L. 1993, I _____ (print name of Physician) certify that I am the physician of _____ (print student's name). This patient suffers from _____ (print name of illness), a potentially life-threatening illness, is capable of, and has been instructed in, the proper method of self-administration of medication for this illness.

Name of Medication _____ Dose/Route _____

Time _____ Additional Instructions _____

Signature of Physician_____ Phone #_____ Date _____

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

State of New Jersey
DEPARTMENT OF EDUCATION

Sudden Cardiac Death Pamphlet

Sign-Off Sheet

Name of School District: SOUTHERN REGIONAL HIGH SCHOOL

Name of Local School: SOUTHERN REGIONAL HIGH SCHOOL

I/We acknowledge that we received and reviewed the Sudden Cardiac Death in Young Athletes pamphlet.

Student Signature: _____

Parent or Guardian
Signature: _____

Date: _____

New Jersey Department of Education 2014: pursuant to the Scholastic Student-Athlete Safety Act, P.L. 2013, c.71