Dear Parents/Guardians,

1. Bergen Catholic High School requires annual physicals for all grade levels (Freshmen, Sophomores, Juniors and Seniors), whether they participate in sports or not. The Doctor must submit a record of immunizations, as it is mandated by the State of New Jersey. The completed medical packet may be downloaded on the Bergen Catholic website, under the "Athletics Tab and then Medical Forms Tab". Please use whichever forms apply to your medical needs.

2. ATHLETICS

Every student athlete, Freshman, Sophomore, Junior, and Senior, participating in the Fall Season must submit a current physical administered by a licensed examining physician within 365 days of the official start date.

Every student athlete must register on ArbiterSports Bergen Catholic's Medical Portal. The link to ArbiterSports can also be found on the Bergen Catholic website, under the "Athletics Tab and then Medical Forms Tab." When registering on ArbiterSports please select 2024-2025 School Year to begin your registration. If your son plans to participate on one of our interscholastic athletic teams, you must complete the information found on the Athletics registration program.

Every student athlete, Freshman, Sophomore, Junior, and Senior, participating in the Fall Season must submit a current physical administered by a licensed examining physician within 365 days of the official start. All Physicals must be uploaded to ArbiterSports in order to be cleared for Try-Outs and Practice. Students participating in Fall sports must be registered on ArbiterSports by June 10th, 2024. This will allow students to participate in practices. All fall athletes then must submit a physical by July 26th, 2024.

Physicals for all students need to be returned, by the first week of school. Physicals, when completed, may be uploaded directly to ArbiterSports.

3. MEDICATION

If your son takes any medication in school, please take special note of the medical slip enclosed. If this slip is **NOT** filled out but your son's doctor, **NO** medication can be administered. This written authorization must be on file in the Nurse's Office at Bergen Catholic High School.

4. PHYSICALS

If your son requires a physical this year, our partner Holy Name Medical Center is offering **free** physicals provided by their physicians at HNH Fitness Center in Oradell, NJ. Please follow these steps to book your appointment.

1. Call (201) 833-3909, indicate you are a Bergen Catholic student-athlete.
2. Print out the state physical form on the Bergen Catholic website and bring to the appointment with you, having completed the family history portion.

Thank you,

Brendan McGovern, Director of Athletics
bmcgovern@bergencatholic.org 201-634-4130

Joe Haemmerle, Associate Athletic Director
jhaemmerle@bergencatholic.org

M. Celeste Tumino, RN, BSN, CSN, School Nurse
ctumino@bergencatholic.org
201-634-2216-Phone
201-634-2200-Fax

Michael Vankoppen, Athletic Trainer
mvankoppen@holyname.org

Dominick Barbarulo, Athletic Trainer
dbarbarulo@holyname.org

Bergen Catholic High School Emergency/Illness/Accident Form

Student's graduation year: ______________________________

Student's Name: ______________________________

Parent's Name: ______________________________

Home Address: ______________________________

Home Phone: ______________________________

Father's Cell phone: ______________________________

Mother's Cell phone: ______________________________

Alternate Person to be notified in case of an emergency

Name: ______________________________

Cell Phone: ______________________________

Doctor to be notified in case of an emergency

Name: ______________________________

Number: ______________________________

Hospital preference: ______________________________

List any allergies, physical disorders that the student has:

____

____

If emergency treatment is required, I hereby authorize the school administration to use their judgment in sending my son to the hospital or the doctor most accessible before I, the parent, can be reached.

Permission is hereby granted to dispense the following nonprescription medications: Non aspirin pain reliever (Tylenol, Advil brand), and Antacid (Tums, Pepto Bismol)

Parent/Guardian Signature: ______________________________

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student-Athlete Cardiac Assessment Professional Development module hosted by the New Jersey Department of Education.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: ______________________ Date of birth: ______________

Date of examination: ______________ Sport(s): ______________________

Sex assigned at birth (F, M, or intersex): ________ How do you identify your gender? (F, M, non-binary, or another gender): ________

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) ____________

List past and current medical conditions. ______________________

Have you ever had surgery? If yes, list all past surgical procedures. ______________________

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?			
10. Have you ever had a seizure?			
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Unsure**	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		

MEDICAL QUESTIONS		Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?			
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?			
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?			
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?			
22. Have you ever become ill while exercising in the heat?			
23. Do you or does someone in your family have sickle cell trait or disease?	Unsure		
24. Have you ever had or do you have any problems with your eyes or vision?			

MEDICAL QUESTIONS (*CONTINUED*)		Yes	No
25. Do you worry about your weight?			
26. Are you trying to or has anyone recommended that you gain or lose weight?			
27. Are you on a special diet or do you avoid certain types of foods or food groups?			
28. Have you ever had an eating disorder?			
MENSTRUAL QUESTIONS	**N/A**	**Yes**	**No**
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: ______________________________

Signature of parent or guardian: ______________________________

Date: ______________________________

© 2023 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student - Athlete Cardiac Assessment Professional Development module Hosted by the New Jersey Department of Education.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

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, e-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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) ________		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): ______________________________ Date: ______________

Address: ______________________________ Phone: ______________

Signature of health care professional: ______________________________, MD, DO, NP, or PA

© 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

Preparticipation Physical Evaluation Medical Eligibility Form

The Medical Eligibility Form is the only form that should be submitted to school. It should be kept on file with the student's school health record.

Student Athlete's Name ______________________________ Date of Birth ____________________

Date of Exam ______________________________

- ○ Medically eligible for all sports without restriction
- ○ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of
- ○ Medically eligible for certain sports
- ○ Not medically eligible pending further evaluation
- ○ Not medically eligible for any sports

Recommendations: ______________________________

I have reviewed the history form and examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings- are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Signature of physician, APN, PA ____________________ Office stamp (optional)

Address: ______________________________

Name of healthcare professional (print) ____________________

I certify I have completed the Cardiac Assessment Professional Development Module developed by the New Jersey Department of Education.

Signature of healthcare provider ______________________________

Shared Health Information

Allergies ______________________________

Medications:

Other information: ______________________________

Emergency Contacts: ______________________________

© 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for noncommercial, educational purposes with acknowledgment.

**This form has been modified to meet the statutes set forth by New Jersey.*

New Jersey Department of Education
Health History Update Questionnaire

Name of School: ______________________________

To participate on a school-sponsored interscholastic or intramural athletic team or squad, each student whose physical examination was completed more than 90 days prior to the first day of official practice shall provide a health history update questionnaire completed and signed by the student's parent or guardian.

Student: ______________________________ Age: ________ Grade: ________

Date of Last Physical Examination: ________________ Sport: ________________

Since the last pre-participation physical examination, has your son/daughter:

1. Been medically advised not to participate in a sport? Yes ☐ No ☐
   If yes, describe in detail:
2. Sustained a concussion, been unconscious or lost memory from a blow to the head? Yes ☐ No ☐
   If yes, explain in detail:
3. Broken a bone or sprained/strained/dislocated any muscle or joints? Yes ☐ No ☐
   If yes, describe in detail.
4. Fainted or "blacked out?" Yes ☐ No ☐
   If yes, was this during or immediately after exercise?
5. Experienced chest pains, shortness of breath or "racing heart?" Yes ☐ No ☐
   If yes, explain
6. Has there been a recent history of fatigue and unusual tiredness? Yes ☐ No ☐
7. Been hospitalized or had to go to the emergency room? Yes ☐ No ☐
   If yes, explain in detail
8. Since the last physical examination, has there been a sudden death in the family or has any member of the family under age 50 had a heart attack or "heart trouble?" Yes ☐ No ☐
9. Started or stopped taking any over-the-counter or prescribed medications? Yes ☐ No ☐
10. Been diagnosed with Coronavirus (COVID-19)? Yes ☐ No ☐

    If diagnosed with Coronavirus (COVID-19), was your son/daughter symptomatic? Yes ☐ No ☐

    If diagnosed with Coronavirus (COVID-19), was your son/daughter hospitalized? Yes ☐ No ☐

Date: ________________ Signature of parent/guardian: ______________________________

Please Return Completed Form to the School Nurse's Office

NJS Department of Health
IMMUNIZATION RECORD

NAME OF CHILD (Last, First, MI)

Date of Birth (M/D/Y)

Sex ☐ M ☐ F

VACCINE TYPE	Disease Mo./Yr.	PRIMARY SERIES 1st Dose Mo./Day/Yr.	2nd Dose Mo./Day/Yr	3rd Dose Mo./Day/Yr	BOOSTERS Mo./Day/Yr.	Mo./Day/Yr.	Mo./Day/Yr.
Diphtheria & Tetanus (DPT and/or TD)	☐	☐	☐	☐	☐	☐	☐
Polio-Inactivated Polio (IPV) If oral vaccine, indicate OPV							
Meningococcal							
Varicella							
Hepatitis A #1, #2							
Measles							
Mumps							
Rubella							
Contra-Indications (Kind)			Reactions (Type)				
Hepatitis B							
H.I.B							
Other							

Mantoux Tuberculin Test Date________________ Result_________ If positive, did student have chest X-Ray?__________ Result

Physician's Signature____ Date of Examination____________________

Physician's Address____

NURSE ADMINISTRATION OF MEDICATION IN SCHOOL

NAME OF STUDENT______________________________ GRADE______________

DIAGNOSIS____

MEDICATION____

DOSAGE______________________ FREQUENCY______________________

DIRECTIONS____

POSSIBLE SIDE EFFECTS____

I authorize the School Nurse to administer the above medication:

____

Signature of M.D. Date

____

Signature of Parent/Guardian Date

____

Physician's Street Address

____

Town & Zip Code

____

Telephone Number

____

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

I certify that this student has asthma or another potentially life-threatening illness and is permitted to self-administer the above medication. He/she has been instructed in the proper techniques of self-administration and has demonstrated competence in this technique.

____

Signature of Prescribing Physician

____

Date

____

Address

____

Telephone Number

****

I authorize my child to self-administer the above medication. This permission includes self-administration of medication during regular school hours and at other times when my child is participating in a school-related event. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the self-administration of this medication and that I will indemnify and hold harmless the district, school, school nurses and other school employees against any claims arising from the self-administration of medication by my child.

Date__________________ Parent/Guardian Signature______________________________

BOTTOM PORTION OF THIS FORM TO BE FILLED OUT ONLY IF STUDENT SELF-MEDICATES.