RUTGERS PRE-COLLEGE SUMMER PROGRAM
REQUIRED MEDICAL FORMS INSTRUCTIONS

- The due date for all medical forms is June 1
- All physical evaluations/forms must be dated within one year of attending the summer program.
- Use only the forms supplied in this package. Substitute forms will not be accepted.
- Medical forms must be submitted via Certified Mail. We will not accept via email, fax, in-person hard-copy submissions or via upload/file sharing.
- Late, missing, incomplete forms or forms unsigned by a physician may result in your child/student not being able to participate in classes or move into the dorms (if registered as a resident).

1. Print all pages in this package.
2. Parent/Guardian: Fill out and sign (in ink) Section I of the Universal Child Health form
3. Parent/Guardian: Fill out and sign (in ink) the following sections of the Preparticipation Physical Evaluation form (DANCE CONSERVATORY & PRE-CONSERVATORY PARTICIPANTS ONLY!)
   a. History Form (and if necessary, the Please explain all “yes” answers page.)
   b. Supplemental History Form
4. If your child has special medical or dietary needs:
   a. Read the Summer Camps/Groups Specialized Dietary Needs Procedure page
   b. Parent/Guardian fill out (in ink) Section I of the Summer Camps and Groups Medical & Dietary Considerations form
5. Bring the following forms to be completed/signed by your child’s doctor/health care provider:
   a. Universal Child Health (Section II to be filled out and signed by the doctor)
   b. Preparticipation Physical Evaluation form comprised of the following
      i. History Form
      ii. Supplemental History Form
      iii. Physical Evaluation Form (to be filled out and signed by the doctor)
      iv. Clearance Form (to be filled out and signed by the doctor)
   c. If special medical/dietary needs: Summer Camps and Groups Medical & Dietary Considerations form (Section II to be filled out and signed by the doctor)
   d. Obtain a copy of your child’s most recent Immunization Records
   e. Obtain a prescription for additional medical necessities such as inhalers or epi-pens. The student should pack one (inhaler, epi-pen or other necessity) in his/her dance bag and an additional should be provided for storage in the director’s office in the event of emergency.
6. Make a copy of the front and back of your medical insurance card and prescription card.
7. Parent/Guardian and Student: Sign and date (in ink) the Permission to Treat Form.
8. Photocopy all completed/signed forms for your own personal records.
9. Package the following completed/signed forms in a 9”x12” envelope in the following order*:

- Universal Child Health Form
- Immunization Record
- Photocopy of Insurance Card (front & back)
- Photocopy of Prescription Card (front & back)
- Preparticipation Physical Evaluation
  - History Form
  - Supplemental History Form
  - Physical Evaluation Form
  - Clearance Form
- Medical & Dietary Considerations Form (if necessary)
- Permission to Treat Form
- Recent photo/headshot of your child/student (ex: school photo)

*The Rutgers Pre-College Summer Dance Program will only accept envelopes with all of the above forms included and completed in entirety. Do not mail until all forms are complete/included.

10. Address the envelope to:

   Attn: Summer Programs  
   Mason Gross Extension Division  
   Rutgers University  
   85 George Street  
   New Brunswick, NJ 08901

11. Fill out a Certified Mail ticket at your local US Postal Office:
   a. Mason Gross Summer Programs will ONLY ACCEPT CERTIFIED MAIL ENVELOPES containing the required medical forms
   b. Requires a small fee at the post office
   c. Retain the certified mail stub in order to be able to track your envelope and obtain confirmation of delivery

12. If you filled out a Medical & Dietary Considerations Form you MUST ALSO fax or mail this form at least TWO WEEKS PRIOR TO THE PROGRAM* to:

   RU Express/Board Plan Office  
   Fax: 732-932-3915  
   Records Hall, Room 102  
   620 George Street  
   New Brunswick, NJ 08901

*Mason Gross is not responsible for forwarding your form to the RU Express/Board Plan Office. If dietary forms are not submitted by the parent/guardian to the RU Express/Board Plan Office at least two weeks in advance of the program, Rutgers Dining Services will not be able to supply a meal plan for the student and families will be responsible/required to provide all meals for their children.
**SECTION I - TO BE COMPLETED BY PARENT(S)**

<table>
<thead>
<tr>
<th>Child's Name (Last)</th>
<th>(First)</th>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>/ /</td>
</tr>
</tbody>
</table>

- Does Child Have Health Insurance? [ ] Yes [ ] No
  
  If Yes, Name of Child's Health Insurance Carrier

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
<th>Home Telephone Number</th>
<th>Work Telephone/Cell Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
<th>Home Telephone Number</th>
<th>Work Telephone/Cell Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**I give my consent for my child’s Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.**

Signature/Date

This form may be released to WIC. [ ] Yes [ ] No

---

**SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER**

Date of Physical Examination: Results of physical examination normal? [ ] Yes [ ] No

Abnormalities Noted:

- Weight (must be taken within 30 days for WIC)
- Height (must be taken within 30 days for WIC)
- Head Circumference (if <2 Years)
- Blood Pressure (if ≥3 Years)

**IMMUNIZATIONS**

- Immunization Record Attached
- Date Next Immunization Due:

**MEDICAL CONDITIONS**

- Chronic Medical Conditions/Related Surgeries
  - List medical conditions/ongoing surgical concerns:
    - [ ] None
    - [ ] Special Care Plan Attached
    - Comments

- Medications/Treatments
  - List medications/treatments:
    - [ ] None
    - [ ] Special Care Plan Attached
    - Comments

- Limitations to Physical Activity
  - List limitations/special considerations:
    - [ ] None
    - [ ] Special Care Plan Attached
    - Comments

- Special Equipment Needs
  - List items necessary for daily activities
    - [ ] None
    - [ ] Special Care Plan Attached
    - Comments

- Allergies/Sensitivities
  - List allergies:
    - [ ] None
    - [ ] Special Care Plan Attached
    - Comments

- Special Diet/Vitamin & Mineral Supplements
  - List dietary specifications:
    - [ ] None
    - [ ] Special Care Plan Attached
    - Comments

- Behavioral Issues/Mental Health Diagnosis
  - List behavioral/mental health issues/concerns:
    - [ ] None
    - [ ] Special Care Plan Attached
    - Comments

- Emergency Plans
  - List emergency plan that might be needed and the signs/symptoms to watch for:
    - [ ] None
    - [ ] Special Care Plan Attached
    - Comments

**PREVENTIVE HEALTH SCREENINGS**

<table>
<thead>
<tr>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Record Value</th>
<th>Type Screening</th>
<th>Date Performed</th>
<th>Note if Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hgb/Hct</td>
<td>Hearing</td>
<td></td>
<td>Vision</td>
<td>Dental</td>
<td>Developmental</td>
</tr>
<tr>
<td>Lead: [ ] Capillary [ ] Venous</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB (mm of Induration)</td>
<td></td>
<td>Vision</td>
<td></td>
<td>Dental</td>
<td>Developmental</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

- I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print)

Health Care Provider Stamp:

Signature/Date
Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860.
   - The Immunization record must be attached for the form to be valid.
   - “Date next immunization is due” is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.
   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.
   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

   PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

   Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.
STAPLE A COPY OF THE STUDENT’S IMMUNIZATION RECORDS HERE
<table>
<thead>
<tr>
<th>FRONT</th>
<th>BACK</th>
</tr>
</thead>
</table>

STAPLE A COPY OF MEDICAL INSURANCE CARD HERE (FRONT AND BACK)

<table>
<thead>
<tr>
<th>FRONT</th>
<th>BACK</th>
</tr>
</thead>
</table>

STAPLE A COPY OF MEDICAL PRESCRIPTION CARD HERE (FRONT AND BACK)
### Preparticipation Physical Evaluation

**HISTORY FORM**

*(Note: This form is to be filled out by the student and parent (if student is under 18) prior to seeing the physician. The physician should keep this form in the chart.)*

**Date of Exam**

Name

Gender

Age

Date of birth

<table>
<thead>
<tr>
<th>Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do you have any allergies?</th>
<th>Yes</th>
<th>No</th>
<th>If yes, please identify below.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines</td>
<td>Pollens</td>
<td>Food</td>
<td>Latex</td>
</tr>
</tbody>
</table>

**GENERAL QUESTIONS**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever denied or restricted your participation in dance or sport activity for any reason?</td>
<td></td>
</tr>
<tr>
<td>2. Do you have any ongoing medical conditions? If so, please identify below: Asthma, Anemia, Diabetes, Infections, Other:</td>
<td></td>
</tr>
<tr>
<td>3. Have you ever spent the night in the hospital?</td>
<td></td>
</tr>
<tr>
<td>4. Have you ever had surgery?</td>
<td></td>
</tr>
</tbody>
</table>

**HEART HEALTH QUESTIONS ABOUT YOU**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Have you ever passed out or nearly passed out during or after exercise?</td>
<td></td>
</tr>
<tr>
<td>6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
<td></td>
</tr>
<tr>
<td>7. Does your heart ever race or skip beats (irregular beats) during exercise?</td>
<td></td>
</tr>
<tr>
<td>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, Kawasaki disease, Other:</td>
<td></td>
</tr>
<tr>
<td>9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)</td>
<td></td>
</tr>
<tr>
<td>10. Do you get lightheaded or feel more short of breath than expected during exercise?</td>
<td></td>
</tr>
<tr>
<td>11. Have you ever had an unexplained seizure?</td>
<td></td>
</tr>
<tr>
<td>12. Do you get more tired or short of breath more quickly than your friends during exercise?</td>
<td></td>
</tr>
</tbody>
</table>

**HEART HEALTH QUESTIONS ABOUT YOUR FAMILY**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arthrogryphic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?</td>
<td></td>
</tr>
<tr>
<td>15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?</td>
<td></td>
</tr>
<tr>
<td>16. Has anyone in your family had an unexplained fainting, unexplained seizures, or near drowning?</td>
<td></td>
</tr>
</tbody>
</table>

**BONE AND JOINT QUESTIONS**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?</td>
<td></td>
</tr>
<tr>
<td>18. Have you ever had any broken or fractured bones or dislocated joints?</td>
<td></td>
</tr>
<tr>
<td>19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</td>
<td></td>
</tr>
<tr>
<td>20. Have you ever had a stress fracture?</td>
<td></td>
</tr>
<tr>
<td>21. Have you ever been told that you or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or other)</td>
<td></td>
</tr>
<tr>
<td>22. Do you regularly use a brace, orthotics, or other assistive device?</td>
<td></td>
</tr>
<tr>
<td>23. Do you have a bone, muscle, or joint injury that bothers you?</td>
<td></td>
</tr>
<tr>
<td>24. Do any of your joints become painful, swollen, feel warm, or look red?</td>
<td></td>
</tr>
</tbody>
</table>

**MEDICAL QUESTIONS**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>26. Have you ever taken a blood pressure medication?</td>
<td></td>
</tr>
<tr>
<td>27. Have you ever used an inhaler or taken asthma medicine?</td>
<td></td>
</tr>
<tr>
<td>28. Is there anyone in your family who has asthma?</td>
<td></td>
</tr>
<tr>
<td>29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?</td>
<td></td>
</tr>
<tr>
<td>30. Do you have groin pain or a painful bulge or hernia in the groin area?</td>
<td></td>
</tr>
<tr>
<td>31. Have you had infectious mononucleosis (mono) within the last month?</td>
<td></td>
</tr>
<tr>
<td>32. Do you have any rashes, pressure sores, or other skin problems?</td>
<td></td>
</tr>
<tr>
<td>33. Have you had a herpes or MRSA skin infection?</td>
<td></td>
</tr>
<tr>
<td>34. Have you ever had a head injury or concussion?</td>
<td></td>
</tr>
<tr>
<td>35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?</td>
<td></td>
</tr>
<tr>
<td>36. Do you have a history of seizure disorder?</td>
<td></td>
</tr>
<tr>
<td>37. Do you have headaches with exercise?</td>
<td></td>
</tr>
<tr>
<td>38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?</td>
<td></td>
</tr>
<tr>
<td>39. Have you ever been unable to move your arms or legs after being hit or falling?</td>
<td></td>
</tr>
<tr>
<td>40. Have you ever become ill while exercising in the heat?</td>
<td></td>
</tr>
<tr>
<td>41. Do you get frequent muscle cramps when exercising?</td>
<td></td>
</tr>
<tr>
<td>42. Do you or someone in your family have sickle cell trait or disease?</td>
<td></td>
</tr>
<tr>
<td>43. Have you had any problems with your eyes or vision?</td>
<td></td>
</tr>
<tr>
<td>44. Have you had any eye injuries?</td>
<td></td>
</tr>
<tr>
<td>45. Do you wear glasses or contact lenses?</td>
<td></td>
</tr>
<tr>
<td>46. Do you wear protective eyewear, such as goggles or a face shield?</td>
<td></td>
</tr>
<tr>
<td>47. Do you worry about your weight?</td>
<td></td>
</tr>
<tr>
<td>48. Are you trying to lose weight?</td>
<td></td>
</tr>
<tr>
<td>49. Are you on a special diet or do you avoid certain types of foods?</td>
<td></td>
</tr>
<tr>
<td>50. Have you ever had or thought you might have an eating disorder?</td>
<td></td>
</tr>
<tr>
<td>51. Do you have any concerns that you would like to discuss with a doctor?</td>
<td></td>
</tr>
</tbody>
</table>

**FEMALES ONLY**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>52. Have you ever had a menstrual period?</td>
<td></td>
</tr>
<tr>
<td>53. How old were you when you had your first menstrual period?</td>
<td></td>
</tr>
<tr>
<td>54. How many periods have you had in the last 12 months?</td>
<td></td>
</tr>
</tbody>
</table>

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of student

Signature of parent/guardian (if student is under 18)

Date

---

Preparticipation Physical Evaluation

PLEASE EXPLAIN ALL “YES” ANSWERS AND REFER TO QUESTIONS NUMBER
# Preparticipation Physical Evaluation

## SUPPLEMENTAL HISTORY FORM

Date of Exam __________________________

Name __________________________ Date of birth __________________________

Gender ____ Age ______

<table>
<thead>
<tr>
<th>1. Type of disability</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Date of disability</td>
<td></td>
</tr>
<tr>
<td>3. Classification (if available)</td>
<td></td>
</tr>
<tr>
<td>4. Cause of disability (birth, disease, accident/trauma, other)</td>
<td></td>
</tr>
<tr>
<td>5. List the activities you are interested in participating in?</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Do you regularly use a brace, assistive device, or prosthetic?</td>
<td>Yes</td>
</tr>
<tr>
<td>7. Do you use any special brace or assistive device for sports or dance activities?</td>
<td>Yes</td>
</tr>
<tr>
<td>8. Do you have any rashes, pressure sores, or any other skin problems?</td>
<td>Yes</td>
</tr>
<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
<td>Yes</td>
</tr>
<tr>
<td>10. Do you have a visual impairment?</td>
<td>Yes</td>
</tr>
<tr>
<td>11. Do you use any special devices for bowel or bladder function?</td>
<td>Yes</td>
</tr>
<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
<td>Yes</td>
</tr>
<tr>
<td>13. Have you had autonomic dysreflexia?</td>
<td>Yes</td>
</tr>
<tr>
<td>14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
<td>Yes</td>
</tr>
<tr>
<td>15. Do you have muscle spasticity?</td>
<td>Yes</td>
</tr>
<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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 student __________________________ Signature of parent/guardian __________________________ Date ______

## 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**

**Gender**

**BP / ( ) ( ) ( )**

**Pulse**

**Vision R 20/ ( ) ( ) ( )**

**L 20/ ( ) ( ) ( )**

**Corrected**

**ABNORMAL FINDINGS**

### MEDICAL

**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**

**Gastrointestinal (males only)**

**Skin**

- HSV lesions suggestive of MRSA, tinea corporis

**Neurologic**

### MUSCULOSKELETAL

**Neck**

**Back**

**Shoulder/arm**

**Elbow/forearm**

**Wrist/hand/fingers**

**Hip/leg**

**Knee**

**Leg/ankle**

**Foot/toes**

**Functional**

- Duck-walk, single leg hop

### Exceptions

- Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
- Consider GI 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 activities without restriction
- Cleared for all activities without restriction with recommendations for further evaluation or treatment for ___________________________

- Not cleared
  - Pending further evaluation
  - For any sports and dance activities
  - For certain sports or dance activity
  - Reason ___________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) and dance activity 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 student 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 student (and parents/guardians).

Name of physician (print/type): ___________________________  Date: ___________________________

Address: ___________________________  Phone: ___________________________

Signature of physician: ___________________________  MD or DO: ___________________________

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Preparticipation Physical Evaluation

CLEARANCE FORM

Name ___________________________ Gender _________ Age _________ Date of birth _________

☐ Cleared for all sports and dance activities without restriction

☐ Cleared for all sports and dance activities without restriction with recommendations for further evaluation or treatment for ________________________________

☐ Not cleared

☐ Pending further evaluation

☐ For any dance or sports activities

☐ For certain dance or sports activity ________________________________

Recommendations ________________________________

______________________________
______________________________
______________________________
______________________________

I have examined the above-named student and completed the preparticipation physical evaluation. The student does not present apparent clinical contraindications to practice and participate in the sport(s) and dance activity 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 student 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 student (and parents/guardians).

Name of physician (print/type) ___________________________ Date __________

Address ___________________________________________ Phone ___________________________

Signature of physician ___________________________ MD or DO

EMERGENCY INFORMATION

Allergies ________________________________

______________________________
______________________________
______________________________
______________________________

Other information ________________________________

______________________________
______________________________
______________________________
______________________________

Summer Camps/Groups
Specialized Dietary Needs Procedure

*All campers/summer group members who identify themselves as having specialized dietary needs (i.e. food allergies, gluten free diet, diabetic diet, etc) are to be referred to the Dining Services Nutritionist at least two weeks prior to the start of camp. Contact information for the Nutritionist is listed above. A Medical and Dietary Consideration form must be completed two weeks prior to the first day of the camp/group.

*The Nutritionist will speak directly with the camper/group member/parent to develop a Nutrition Care Plan and/or menus to satisfy the specialized dietary requirements documented by a physician.

*The dietary/menu information will be communicated with the appropriate dining hall and catering management staff.

Dining Hall or Catering Management will confirm communication regarding specialized meal request via email. Catering contracts indicating a specialized meal will be sent to the Nutritionist for review.

*When warranted, meals will be individually prepared, plated and labeled with the individual’s name. Upon entering the dining hall or catered event, the individual is to request a manager to retrieve their meal.

*It is the responsibility of the individual to bring with him/her any snacks to be consumed outside of the dining hall as food from the dining hall is not allowed to be taken out.

*Dining Services is only responsible for meals prepared and served through Rutgers Dining Services. Meals received from outside vendors/facilities are not verified by the Dining Services Nutritionist.
SUMMER CAMPS AND GROUPS
MEDICAL & DIETARY CONSIDERATIONS

Important Notes:
1. All sections of this form must be completed before the request can be processed.
2. This form must be received by the Dining Services Nutritionist at least TWO WEEKS prior to the first day of camp. Special dietary requests received after the two week period may not be honored.
3. Completion of this form will initiate a professional review of your nutritional and dietary concerns. Dining Services will work with campers/group member who have special dietary needs to ensure a medically appropriate and nutritionally sound diet.
4. After all sections of the form are completed, please return it to the RU Express/Board Plan Office, Records Hall, Room 102, CAC or faxed to: 732-932-3915. It will then be forwarded to the Dining Services Nutritionist who will contact the camper/parent/group member indicated to discuss individual dietary needs.

I. TO BE COMPLETED BY THE CAMPER/GROUP MEMBER (OR GUARDIAN)

NAME: ___________________________ CONTACT

PERSON: ___________________________

PHONE#: ___________________________ EMAIL ADDRESS: ___________________________

NAME OF CAMP/GROUP: ___________________________ DATE(S) OF

CAMP/GROUP: ___________________________

Please describe the specialized dietary adjustments required:

__________________________________________________________________________________________

__________________________________________________________________________________________

II. TO BE COMPLETED BY PRIVATE PHYSICIAN

Describe briefly your medical findings regarding the individual’s illness and special dietary adjustments required.

__________________________________________________________________________________________

__________________________________________________________________________________________

Physician’s Signature: ___________________________ Date: ___________________________

Print Physician’s Name: ___________________________ Address: ___________________________

Phone #: ___________________________ Fax#: ___________________________

Please suggest dining/nutritional accommodations to be considered for this individual: ___________________________

Physician Signature: ___________________________ Date: ___________________________

Dining Services is only responsible for dietary accommodations for meals prepared and served through Rutgers Dining Services. All meals received from outside vendors/facilities will not be verified by the Dining Services Nutritionist.
New Jersey State Law requires that parental permission be obtained in advance for the diagnosis/treatment of a Minor. This consent form should be signed by a parent or Legal Guardian so that prompt, routine medical care may be delivered without unnecessary delay to a student while he/she is attending a program/conference through Rutgers, the State University of New Jersey.

I, ___________________________, give permission for the staff at Rutgers Health Services (Medical Practitioner/Registered Nurse) to perform a diagnostic evaluation and provide therapeutic treatment of an illness/injury, or referral for diagnosis or treatment, as deemed necessary for my son/daughter, ___________________________.

I certify by my signature that I understand the nature of this consent and agree to its provisions.

__________________________________       _________________________
Signature of Parent/Legal Guardian          Date

__________________________________
Relationship to Minor

__________________________________
Signature of Minor
STAPLE A PHOTO/HEADSHOT OF YOUR CHILD/STUDENT HERE
(EX: SCHOOL PHOTO)