

PHYSICAL ON FILE FORMS

ATHLETIC ELIGIBILITY FORM

Please check one:

- Barnegat High School
 Russell O. Brackman Middle School
 M.A.T.E.S Performing Arts Academy A.L.P.S. Home Schooled

I. Student Information (Please complete this section.)

Name: _____			Home Phone: _____		
Last	First	Middle	Emergency Contact: _____		
Address: _____			Emergency Phone: _____		
Street		Town, State	Zip		
Are you a transfer student? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date of transfer: _____		Previous school: _____	
Date of Birth: _____		Sex: M F		City and State of Birth: _____	
Sport by Season:		Grade (Sept. 2024): _____		Age as of August 31, 2024: _____	
Fall: _____		Winter: _____		Spring: _____	

II. Eligibility Information (This section is filled out by the school.)

Declared Eligible by:	Date	Signature	Comments	Credits Previous Year: (Fall/Winter Seasons)	Credits 1 st Semester: (Spring Season)
Guidance					
Medical				Physical Date: _____	
Athletic Office					
Principal					

III. Barnegat Township Parental Permission (Please read and complete this section.)

1. I give my son/daughter _____ permission to participate in the interscholastic sport of _____.
2. I understand Russell O. Brackman Middle School students must meet District Policy 2430 criteria to be eligible to participate.
I understand Barnegat High School students must meet NJSIAA eligibility requirements to participate.
3. I recognize that my son/daughter must have a comprehensive medical examination by the Medical Home recorded on the appropriate form prior to participation on any athletic team. In addition, a comprehensive medical history, recorded on the appropriate form, must accompany the student/athlete at the time of the physical. Both forms must be signed by the examining physician and filed with the health office.
4. I waive all claims for damages, remuneration, reimbursement or any other expenses in case of personal injury in conduct of the sport program and in all arrangements incidental thereto.
5. I understand that in case of interscholastic sports injury to my child, medical bills will be submitted to my insurance company first. Only those medical expenses not covered by my personal or group insurance are eligible for coverage by the Board of Education insurance policy up to established limits. I also understand that I am liable for any medical bills remaining after the above procedures have been carried out. It is suggested that I obtain personal medical insurance if a health insurance program does not cover my son/daughter.
6. I realize that the use, possession and/or distribution (in or out of school) of any chemical substance in any form are strictly prohibited. Chemical substances include, but are not limited to: alcoholic beverages, tobacco in any form, anabolic steroids, controlled dangerous substances, any chemical which release vapor or fumes causing intoxication inebriation, excitement, stupefaction or dulling of the brain or nervous system, as defined by N.J.S.A. 2A: 170-25.9, any mind altering or behavior altering substances used for purposes other than the treatment of illness, any prescription or over the counter medications except those for which permission to use has been granted. Violation of this policy by any student will invoke immediate sanctions as outlined by the student discipline policy regarding substance abuse.
7. I understand that N.J.A.C. 629.6.4 necessitates inclusion of a "cautionary" statement: Realizing that such activity involves the potential for injury which is inherent in all sports, I acknowledge that even with the best coaching, the use of the most protective equipment and strict observance of rules, injuries can be so severe as to result in total disability, paralysis or even death. I acknowledge/understand this warning.

I have read and understand the above rules and regulations.

DATE: _____	
	Signature of Parent/Guardian
DATE: _____	
	Signature of Student



BARNEGAT SCHOOL DISTRICT ATHLETE EMERGENCY CONTACT FORM

(Coaches please keep this form on you to reference)

STUDENT INFORMATION:

Student Name _____ Date of Birth _____

Year in School (**circle**) 6 7 8 9 10 11 12

Address _____

City _____ Zip code _____ Phone # _____

EMERGENCY CONTACT INFORMATION:

Primary Contact Name _____

Relationship _____ Primary phone# _____

Alternate phone # _____

Name of Alternate contact person _____

Relationship _____ Phone # _____

Alternate phone # _____

HEALTH CONDITIONS

(CHECK OFF ALL THAT APPLY):

____ Asthma (**Asthma Action Plan must be on file with the nurse for the current school year**)

____ Diabetes (**Diabetic Medical Management Care Plan must be on file with the nurse for current school year**)

____ Epilepsy (**Seizure Action Plan must be on file with the nurse for the current school year**)

____ Food Allergies (**Food Allergy and Anaphylaxis Emergency Care Plan must be on file with the nurse for the current school year**)

____ Other (please list) _____

In case of emergency, I give permission for my information to be released for emergency purposes. I also agree that any of my emergency contacts listed may be notified in an emergency, as needed.

Parent Signature _____ Date _____

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