

Audubon Junior-Senior High School

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ATHLETIC PARTICIPATION

Dear Parent/Guardian,

Please be advised that this year the Athletic Department has put into place a new process for registering students for all sports. Please review the following information related to the Audubon High School Athletic Program.

Note: You will need to log into your Genesis Parent Portal to access the forms. If you need help accessing your Parent Portal, please email Mike Chisholm in our Tech Department at mpchisholm@audubonschools.org or 856- 547-7695 ext. 4217.

Please follow the steps below to register your student for sports:

- 1. Complete the attached <u>Physical Athletic Packet</u>. (Due every 365 days) and return to Ms. Coombs in room C-102.
- 2. To register, complete the athletic forms in your <u>Parent Genesis Portal</u> at https://www.audubonschools.org/ a. Click on "Parents/Students" in the tab on the top of the page.
 - b. Click on "Parent Genesis" and log into your parent portal.
 - c. Click on "Forms" in the blue ribbon on the top of the page and select "Sports Sign-ups"
- 3. Athletes must complete an ImPACT Test (concussion baseline test) every two years.
 - a. Go to ImPACTtestonline.com/schools
 - b. Use customer code: 3BA1F6971C
- 4. Submit <u>Activity Fee</u> online or complete Activity Fee Form in this packet.

The registration process must be completed, and the medical forms, when needed, should be returned to Ms. Coombs in Room C-102. All steps must be completed prior to Friday, July 14, 2023 in order to be processed for the first day of practice. Paperwork received after July 14th may jeopardize a student athlete's ability to participate in their sport until they have been cleared. There will be no same day approvals. All paperwork including physicals will take a minimum of seven days to process and approve.

If you have any questions, please do not hesitate to call Ms. Coombs at 856-547-7695 ext. 4123. Sincerely,

Tony Carbone Athletic Director

"A Tradition of Pride and Excellence"

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 keepa 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 ☐ Yes ☐ No If yes, please identify specific allergy below. Do you have any allergies? ☐ Medicines ☐ Pollens ☐ Stinging Insects Explain "Yes" answers below. Circle questions you don't know the answers to. MEDICAL QUESTIONS Yes No **GENERAL QUESTIONS** No 26. Do you cough, wheeze, or have difficulty breathing during or 1. Has a doctor ever denied or restricted your participation in sports for after exercise? any reason? 2. Do you have any ongoing medical conditions? If so, please identify 27. Have you ever used an inhaler or taken asthma medicine? 28. Is there anyone in your family who has asthma? below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections 29. Were you born without or are you missing a kidney, an eye, a testicle 3. Have you ever spent the night in the hospital? (males), your spleen, or any other organ? 4. Have you ever had surgery? 30. Do you have groin pain or a painful bulge or hernia in the groin area? HEART HEALTH QUESTIONS ABOUT YOU No Yes 31. Have you had infectious mononucleosis (mono) within the last month? 5. Have you ever passed out or nearly passed out DURING or 32. Do you have any rashes, pressure sores, or other skin problems? AFTER exercise? 33. Have you had a herpes or MRSA skin infection? 6. Have you ever had discomfort, pain, tightness, or pressure in your 34. Have you ever had a head injury or concussion? chest during exercise? 35. Have you ever had a hit or blow to the head that caused confusion, 7. Does your heart ever race or skip beats (irregular beats) during exercise? prolonged headache, or memory problems? 8. Has a doctor ever told you that you have any heart problems? If so, 36. Do you have a history of seizure disorder? check all that apply: 37. Do you have headaches with exercise? ☐ High blood pressure ☐ A heart murmur 38. Have you ever had numbness, tingling, or weakness in your arms or ☐ High cholesterol ☐ A heart infection Other: legs after being hit or falling? ☐ Kawasaki disease 39. Have you ever been unable to move your arms or legs after being hit 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, or falling? echocardiogram) 40. Have you ever become ill while exercising in the heat? 10. Do you get lightheaded or feel more short of breath than expected 41. Do you get frequent muscle cramps when exercising? during exercise? 11. Have you ever had an unexplained seizure? 42. Do you or someone in your family have sickle cell trait or disease? 12. Do you get more tired or short of breath more quickly than your friends 43. Have you had any problems with your eyes or vision? during exercise? 44. Have you had any eye injuries? **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** Yes No 45. Do you wear glasses or contact lenses? 13. Has any family member or relative died of heart problems or had an 46. Do you wear protective eyewear, such as goggles or a face shield? unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? 47. Do you worry about your weight? 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan 48. Are you trying to or has anyone recommended that you gain or syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic 49. Are you on a special diet or do you avoid certain types of foods? polymorphic ventricular tachycardia? 50. Have you ever had an eating disorder? 15. Does anyone in your family have a heart problem, pacemaker, or 51. Do you have any concerns that you would like to discuss with a doctor? implanted defibrillator? FEMALES ONLY 16. Has anyone in your family had unexplained fainting, unexplained 52. Have you ever had a menstrual period? seizures, or near drowning? **BONE AND JOINT QUESTIONS** Yes No 53. How old were you when you had your first menstrual period? 54. How many periods have you had in the last 12 months? 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? Explain "yes" answers here 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? 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/quardian

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

PREPARTICIPATION PHYSICAL EVALUATION THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of	Exam						
Name				Date of birth			
Sex	Age	Grade	School				
	Age	drado	3011001	opora(o)			
	e of disability						
	e of disability						
3. Cla	ssification (if available)						
4. Car	use of disability (birth, di	sease, accident/trauma, oth	er)				
	t the sports you are inte						
					Yes	No	
		ce, assistive device, or prostl					
		ce or assistive device for sp					
_		essure sores, or any other s					
		? Do you use a hearing aid?					
	you have a visual impai	rment? rices for bowel or bladder fu	nation?				
		comfort when urinating?	AGUOTT?				
	ve you had autonomic d						
			perthermia) or cold-related (hypothermia) illn	2000			
	you have muscle spasti		or and rolling or and rolling (rypostorma) mil				
		res that cannot be controlle	d by medication?				
	"yes" answers here						
Explain	yes unawers note						
				-			
Dianaai	ndicate if you have ou	er had any of the following					
		or mad any or the ronowing			Yes	No No	
	axial instability		MONTH MENTAL THE THE PARTY AND THE PARTY				
	valuation for atlantoaxia	al instability					
	ted joints (more than or	The state of the s					
Easy b							
Enlarge	ed spleen					1	
Hepati	tis						
Osteop	Osteopenia or osteoporosis						
Difficu	ty controlling bowel						
Difficu	ty controlling bladder						
Numbr	ess or tingling in arms o	or hands					
Numbr	ness or tingling in legs o	r feet					
Weakn	ess in arms or hands						
	ess in legs or feet						
	change in coordination						
	change in ability to wal	k					
Spina							
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.							
Signatur	e of athlete		Signature of parent/guardian		Date		

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 FXAMINATION FORM

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 ☐ Male ☐ Female Height Weight BP Vision R 20/ Corrected DY N ABNORMAL FINDINGS NORMAL 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^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 . 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 *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

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Signature of physician, APN, PA

PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name	Sex L	」M □ F Age	Date of birth
☐ Cleared for all sports without restriction			
☐ Cleared for all sports without restriction wi	th recommendations for further evaluation	or treatment for	
□ Not cleared			
☐ Pending further evaluation			
☐ For any sports			
Recommendations			
EMERGENCY INFORMATION			
Allergies			
Other information			
HCP OFFICE STAMP		SCHOOL PHYSICIAN:	
		Reviewed on(Date)	
		Approved Not Approved	
		Signature:	
		Signature:	
I have examined the above-named stu- clinical contraindications to practice a and can be made available to the scho the physician may rescind the clearan (and parents/guardians).	and participate in the sport(s) as out ool at the request of the parents. If o	tlined above. A copy of the physical e conditions arise after the athlete has	exam is on record in my office been cleared for participation,
	450		
Name of physician, advanced practice nurs			
		Ph	one
Signature of physician, APN, PA			
Completed Cardiac Assessment Profession			
Date Si	gnature		

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My Asthma Action Plan For Home and School

Severity Classification: Intermittent Mild Persistent Severe Persistent Severe Persistent Asthma Triggers (list): Peak Flow Meter Personal Best: Persistent					
Green Zone: Doing	g Well				
Symptoms: Breathing	g is good – No cough or wheeze	– Can work ar	The state of the s	vell at night	
Control Medicine(s)		How much to		When and how often to take i	_ Home School
Physical Activity	Use Albuterol/Levalbuterol			with all activity whe	_
Yellow Zone: Caut	lon				
Symptoms: Some problems breathing – Cough, wheeze, or tight chest – Problems working or playing – Wake at night Peak Flow Meter to (between 50% and 79% of personal best)					
Quick-relief Medicine(s) Albuterol/Levalbuterol puffs, every 4 hours as needed Control Medicine(s) Continue Green Zone medicines Add Change to					
	within 20–60 minutes of the quoillow the instructions in the REI	uick-relief treat	ment. If you are g	etting worse or are in the Ye	
Red Zone: Get Hel	p Now!				
Symptoms: Lots of problems breathing – Cannot work or play – Getting worse instead of better – Medicine is not helping Peak Flow Meter (less than 50% of personal best)					
	dicine NOW!	are present:		alking due to shortness of brace blue	eath
The only control medicine	Yellow and Red Zone instruction es to be administered in the scho ovider and the Parent/Guardian f	ol are those list	ed in the Green Zo	ne with a check mark next to	o "Take at School".
	uding when to tell an adult if sym				adifili lister trieli
Healthcare Provider Name	Date	Phone (_)	Signature	
Parent/Guardian I give permission for the medicines listed in the action plan to be administered in school by the nurse or other school staff as appropriate. I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medicine.					
	Date			Signature	
School Nurse The student has demonstrated the skills to carry and self-administer their quick-relief inhaler, including when to tell an adult if symptoms do not improve after taking the medicine.					
Name	Date	Phone (_)	Signature	

AUDUBON JUNIOR-SENIOR HIGH SCHOOL STUDENT ACTIVITY FEE 2023-2024

The Student Activity Fee is used to support athletics and extra-curricular activities at the junior-senior high school. The \$100.00 fee for grades 9-12 and \$75.00 fee for grades 7 & 8 (6th graders in the JHS wrestling program) covers participation in all sports, activities and clubs. The maximum fee for one family is \$150.00. One hundred percent of the funds collected will go directly back to programs for students.

\$75.00 (JrHS-7/8th grade student) - \$100.00 (9-12 grade student) OR \$150.00 (family)

Audubon High School offers Parents/Guardians the option of paying this fee on-line at Pay4SchoolStuff. Please go to:

Audubonschools.org, select the Audubon High School tab, and click on On-Line Payment Options. Parent Quick Start Instruction will guide you thru the payment process

AUDUBON JUNIOR-SENIOR HIGH SCHOOL SPORTS AND ACTIVITIES SUBJECT TO THIS FEE ARE:

All Junior & Senior High School Athletics
Marching Band Jazz Band

Chess Club
Choral Ensemble

Fall & Spring Plays Percussion Ensemble

Challenge Bowl

ACTIVITIES THAT ARE NOT SUBJECT TO THE ACTIVITY FEE INCLUDE:

Flag Football & Intramural Tennis (7th & 8th grade)

All Service Related Clubs (Nat'l Honor Society, EMS, Stage Crew, etc.)

Students who qualify for free or reduced price lunches will be exempt from the activity fee provided that the appropriate paperwork has been turned in for the 2023-2024 school year.

Please list below the full name(s), grade level and *all sports/activities* of each student covered by this payment. Checks should be made payable to **AHS ACTIVITY FUND**

Please co	omplete this form and return it to the Athletic office (C102) prior to practice or the start of your
activity.	If you have any questions, please call (856) 547-7695 ext. 4123.
	CTUDENT ACTIVITY EEE
	STUDENT ACTIVITY FEE

2023-2024 Last Name First Name Grade Sport/Activity Amount

My student has already paid the Student Activity Fee for the 2023-2024 School Year

Paid by Cash/Check #____ (your canceled check is your receipt)

Date of Payment _____