



Audubon Junior-Senior High School

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www.audubonschools.org

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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 Physical Athletic Packet. (Due every 365 days) and return to Ms. Coombs in room C-102.
2. To register, complete the athletic forms in your Parent Genesis Portal 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 Activity Fee 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"

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.

[illegible]

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 _____

NOTE: The preparticipation 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

- 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP	/	(/)	Pulse
Vision R 20/		L 20/	Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 			
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 			
Lymph nodes			
Heart* <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 			
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 			
Lungs			
Abdomen			
Genitourinary (males only) ^b			
Skin <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Duck-walk, single leg hop 			

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider 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 _____

■ 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 _____



My Asthma Action Plan For Home and School

Name: _____ DOB: ____/____/____

Severity Classification: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best: _____

Green Zone: Doing Well

Symptoms: Breathing is good – No cough or wheeze – Can work and play – Sleeps well at night

Peak Flow Meter _____ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it	Take at
	_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> School
	_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> School

Physical Activity ☐ Use Albuterol/Levalbuterol _____ puffs, 15 minutes before activity ☐ with all activity ☐ when you feel you need it

Yellow Zone: Caution

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 _____

You should feel better within 20–60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help 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)

Take Quick-relief Medicine NOW! ☐ Albuterol/Levalbuterol _____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present:

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes

School Staff: Follow the Yellow and Red Zone instructions for the quick-relief medicines according to asthma symptoms. The only control medicines to be administered in the school are those listed in the Green Zone with a check mark next to “Take at School”.

☐ Both the Healthcare Provider and the Parent/Guardian feel that the child 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.

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.

Name _____ Date _____ Phone (____) ____ - ____ 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 _____

Please send a signed copy back to the provider listed above.

1-800-LUNGUSA | Lung.org

**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	Chess Club	Fall & Spring Plays
Marching Band	Jazz Band	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 complete 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.

**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 _____