



Dear Arrow Academy friends and families,

My name is Susan Peluso, I am writing to introduce myself as the new-full time school nurse at Arrow Academy. Many of you may already know me from this past school year working as the part-time nurse and TA in the pre-k class.

I absolutely love being a school nurse and am honored to have the privilege of working with the students here at Arrow Academy. I approach my nursing practice with the attitude of “what would I do if this were my child?” and I want to assure you that your child’s health and safety is my number one priority.

I have been a registered nurse for the past 26 years, 15 of which I have worked as a substitute school nurse. I have always worked in pediatrics because of my love for working with children.

I will now be in the Health Office daily, should you want to drop off medications, discuss any concerns or just say hello and introduce yourself.

Please feel free to email me at [susan@thearrowacademy.org](mailto:susan@thearrowacademy.org) with any questions or concerns.

I’m looking forward to a great school year.

Sincerely,  
Susan Peluso RN

# 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.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
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 syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
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?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

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\_\_\_\_\_

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 • 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 <sup>a</sup> • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) <sup>b</sup>		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic <sup>c</sup>		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

<sup>a</sup>Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.  
<sup>c</sup>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 \_\_\_\_\_  
 Signature of physician, APN, PA \_\_\_\_\_

# ■ 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		
	<b>Yes</b>	<b>No</b>
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

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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

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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 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 \_\_\_\_\_



**To the Examining Healthcare Provider:**

In order to ensure that the health office has a completed and updated health record for your patient/athlete, please complete the information below, sign and stamp in the space provided.

Thank you very much for your cooperation.

**Medications currently prescribed, with dose and frequency:**

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**Most recent immunizations and DATES administered:**

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\_\_\_\_\_  
Date of Exam

\_\_\_\_\_  
Provider's Signature

Provider's Stamp



**SCHOLASTIC STUDENT-ATHLETE SAFETY ACT**  
**INFORMATION FACT SHEET FOR PARENTS/GUARDIANS**

Prior to participation on a school-sponsored interscholastic or intramural athletic team or squad, each student-athlete in grades five through 12 must present a completed pre-participation physical evaluation (PPE) form to the designated school staff member. Important information regarding the PPE is provided below, and you should feel free to share with your child's medical home health care provider.

1. The PPE may **ONLY** be completed by a licensed physician, advanced practice nurse (APN) or physician assistant (PA) that has completed the Student-Athlete Cardiac Assessment professional development module. It is recommended that you verify that your medical provider has completed this module before scheduling an appointment for a PPE.
2. The required PPE must be conducted within 365 days prior to the first official practice in an athletic season. The PPE form is available in English and Spanish at <http://www.state.nj.us/education/students/safety/health/records/athleticphysicalsform.pdf>.
3. The parent/guardian must complete the *History Form* (page one), and insert the date of the required physical examination at the top of the page.
4. The parent/guardian must complete *The Athlete with Special Needs: Supplemental History Form* (page two), if applicable, for a student with a disability that limits major life activities, and insert the date of the required physical examination on the top of the page.
5. The licensed physician, APN or PA who performs the physical examination must complete the remaining two pages of the PPE, and insert the date of the examination on the *Physical Examination Form* (page three) and *Clearance Form* (page four).
6. For student-athletes that had a medical examination completed more than 90 days prior to the first official practice in an athletic season, the *Health History Update Questionnaire* (HHQ) form must be completed, and signed by the student's parent/guardian. The HHQ must be reviewed by the school nurse and, if applicable, the school's athletic trainer. The HHQ is available at <http://www.state.nj.us/education/students/safety/health/records/HealthHistoryUpdate.pdf>.

Please contact the Health Office with any questions.



## Health Office

90 Whippany Rd, Whippany, NJ, 07981

**Susan Peluso RN**

School Nurse

[susan@thearrowacademy.org](mailto:susan@thearrowacademy.org)

Phone: 973-888-2083



## Health Policies

Students who have been ill with diarrhea, vomiting, or fever (100 degree or above) should remain home for 24-48 hours after the symptoms have subsided without the aid of pharmaceuticals.

Students who have been diagnosed with streptococcal infection (strep throat) are to be excluded from school for 24 hours after the start of antibiotic therapy.



## Medication

All medications, including over-the-counter, must be kept in the Health Office. A doctor's note with parental permission must be provided in order to administer medication. Appropriate forms are available in the health office.

Student self-administration of medication for potentially life-threatening illnesses, such as asthma or anaphylactic reaction, is permitted and must also be arranged with the health office.

**NO CHILD IS PERMITTED TO CARRY MEDICATIONS** (Exceptions include self-administration of epi-pens and inhalers).





## Screenings

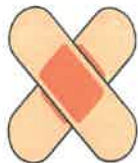
During the year the school nurse performs the following health services:

- Measurement of height and weight of all students
- Vision testing of all students
- Hearing testing of students in grades K-3 & 7
- Scoliosis screening of students age 10-18 years of age
- Blood pressure screenings of all students



## Athletic Information

All students wishing to participate in Athletics at Arrow Academy must have a physical examination within 365 days (1 year) of the first practice on file in the health office, and submit the additional necessary paperwork prior to the day practices begin in order to be eligible. All required forms will be sent home and are available in the health office.



## 6th Grade Required Immunizations

All incoming 6th grade students are required to have the following NJ State mandated immunizations (or an exemption letter on file):

- One dose of Tdap (Tetanus, diphtheria, acellular pertussis) given no earlier than the 10th birthday
- One dose of meningococcal-containing vaccine given on or after the 11th birthday

Students must have the above immunizations prior to the start of the school year. Failure to comply will result in exclusion of your student from school as per NJAC 8:57-4 Immunizations of Pupils in School.



90 Whippany Rd, Whippany, NJ, 07981

**Health Office**

Phone: 973-888-2083

## **MEDICATION PROTOCOL**

Medication will be given in school only when a pupil's health and continuing attendance in school requires it and it is administered in accordance with the medication policy. No student is to carry medication to and from school. If it is necessary that medication be taken during school hours, the following is required:

1. All medication, prescription and over the counter, must be accompanied by a written request from a physician. These orders must include the diagnosis or type of illness, name of drug, dosage, time of administration, length of time for which it is required, and side effects of medication. Written orders must be renewed on an annual basis at the beginning of each school year.
2. A Mandatory Medication Form, Asthma Action Plan and/or Allergy Emergency Treatment form must be completed by the primary care provider and signed by parent/guardian.
3. Medication is to be in the correct prescription bottle, labeled with the name of the child, current dosage, date of prescription, and name of prescribing primary care provider
4. Parents must bring all medications to the Health Office. Students should never carry medication to school unless the doctor specifically orders that the student may carry and self-administer emergency epinephrine or inhaler.
5. Self-administration of medication for asthma or other potentially life-threatening illnesses require additional doctor and parent signatures on the form.
6. Non Prescription medications (i.e. Ibuprofen, Tylenol) may only be administered when a Mandatory Medication Form is completed by the primary care provider and signed by a parent. These medications must come in the original container.
7. According to NJ Law, school nurses cannot administer alternative remedies such as herbal medications and essential oils.
8. No parent's or primary care provider's phone instructions can be accepted.
9. Parents must pick up the medication from the Nurse in June on the last day of school. No medications will be sent home with a student. Medications will be properly disposed of if parents do not pick up the medication on the last day of school.