The Town of Hillside, Code, Section 211-5, et.seq., provides that it is unlawful for any person over the age of 18 to assist, aid, abet, allow, permit or encourage an ineligible student to register or enroll in the Hillside School District, or to knowingly permit or use his or her address or residence in the registration or enrollment of an ineligible student. Anyone who violates the ordinance is subject to a fine of $1000.00 and to the payment of restitution which could include tuition costs, investigation expenses and attorney fees.

HILLSIDE PUBLIC SCHOOLS
STUDENT REGISTRATION: TO BE COMPLETED FOR ALL STUDENTS

PLEASE PRINT

STUDENT

Student's Name_____ Date_____
last first middle

Grade entering_____, Fall 20_____

Student's Address_____

Student's Home Phone_____ Check one: male____ female_____

Date of Birth _____ Birthplace: City_____ State_____ Country_____

Name of school attended in 20_____ school year _____

PARENT(S)/GUARDIAN

Parent Military Affiliation: (Check one) _____ 1. Not Military Connected
_____ 2. Active Military Connected

Please provide the following information about the student's mother/guardian:

Name_____ Address_____

Home phone_____ Cell phone_____ Email_____

Employer's Name, Address, Phone Number _____

_____

Please provide the following information about the student's father/guardian:

Name_____ Address_____

Home phone_____ Cell phone_____ Email_____

Employer's Name, Address, Phone Number _____

_____

(please complete reverse side) **(rev. 2017)**

LANGUAGE/ETHNICITY

Language spoken at home_____ Student's primary language _____

Student's ethnicity: ____African American ____Native American/Alaskan ____Asian
____Hispanic ____ Caucasian(non-Hispanic) ____Pacific Islander/Hawaiian

STUDENT'S BROTHERS AND SISTERS

Names of other children in the family	Birthdate	Grade entering Fall, 20___	School enrolled Fall, 20___
1.			
2.			
3.			

SPECIAL SERVICES (For placement purposes only. This information will be kept confidential.)

Has your child been educationally classified? _____Yes _____No

Has your child been referred to (please check all that apply): _____Child Study Team _____Speech services

_____ESL _____Remedial math or reading services

EMERGENCY CONTACTS: PLEASE LIST TWO
In case an emergency arises and school personnel are unable to reach you, they are to contact the persons below. Please designate persons who can pick up your child from school in case we are unable to reach you.

1. Emergency Contact Name_____ Relationship to student_____

   Emergency Contact Address_____

   Home phone_____ Work phone_____

2. Emergency Contact Name_____ Relationship to student_____

   Emergency Contact Address_____

   Home phone_____ Work phone_____

ATTESTED

I attest that the information provided on this registration form is true and complete. I understand that any individual who procures a public education for any student not lawfully domiciled in Hillside will be subject to liability under state law. Upon disenrolling the student(s), the district reserves the right to recover back tuition payments from the individual involved and to pursue all other relief available by law.

_____ _____
Signature of Parent or Guardian Date

FOR OFFICE USE ONLY
BIRTH CERTIFICATE AND HEALTH RECORDS

Note to school official: birth certificate and health records to be attached for first time enrollees. If presented, check here and copy. _____birth certificate _____health/immunization record

The Town of Hillside, Code, Section 211-5, et.seq., provides that it is unlawful for any person over the age of 18 to assist, aid, abet, allow, permit or encourage an ineligible student to register or enroll in the Hillside School District, or to knowingly permit or use his or her address or residence in the registration or enrollment of an ineligible student. Anyone who violates the ordinance is subject to a fine of $1000.00 and to the payment of restitution which could include tuition costs, investigation expenses and attorney fees.

HILLSIDE PUBLIC SCHOOLS
RESIDENCY AND GUARDIANSHIP VERIFICATION

PLEASE PRINT

STUDENT

Student's Name_____ Date_____
last first middle

Student's Address_____

Student's Home Phone_____ Grade entering_____, Fall, 20_____

TO BE COMPLETED BY SCHOOL PERSONNEL ONLY

RESIDENCY

Proof of legal residence in Hillside presented by parent or guardian at registration
School personnel shall place a check next to proofs presented and attach copies. Three proofs are required.

Category 1 _____ Current Tax Bill _____ Current Mortgage _____ Current Lease

Category 2 _____ Current utility bill for your residence (gas, electric, phone, etc)

Category 3 _____ Driver's License _____ Financial account statement

_____ Current pay stub w/address _____ State Agency document

GUARDIANSHIP

If a student does not live with a parent, documentation of guardianship is required in the form of a court order or a state agency placement document.

Proof of Guardianship presented: _____ court order
_____ state agency placement document

Registration will be complete for a student whose parent or guardian provides the above proofs, subject to verification. The Board retains the right to investigate the residency of any student at any time.

RESIDENCY/GUARDIANSHIP INVESTIGATION

Purpose: _____ Verification of residency _____ Verification of guardianship (if both, place check by both)

Date(s) of Investigation _____

Findings of Residency Investigator _____

_____

Signature of Residency Investigator _____ Date _____

Home Language Survey Form

Introduction

This survey is the first of three steps to identify whether or not a student is eligible to be an English language learner (ELL). Start with "Question 1" and continue until the HLS is complete. Select the answer for each question and follow the directions.

Student Information

Student name: Student birth date:

Street Address:

City: State: Zip Code:

Phone number:

Survey Questions

Question 1

What was the first language used by the student?

A language other than English. Proceed to question 2a.

English. Proceed to question

Question 2a

At home, does the student hear or use a language other than English more than half of the time?

Yes. Proceed to 7.

No. Proceed to question 4.

Question 2b

At home, does the student hear or use a language other than English more than half of the time?

Yes. Proceed to question 4.

No. Proceed to question 3.

Question 3

Does the student understand a language other than English?

Yes. Proceed to question 4.

No. Proceed to 9.

Question 4

When interacting with his/her parents or guardians, does the student use a language other than English more than half of the time?

Yes. Proceed to 7.

No. Proceed to question 5.

IMPORTANT- PLEASE READ

As you know, social media continues to play an increasingly important role in our everyday lives. By signing off on this document, you also provide permission for The Hillside Public Schools to use photos/images/videos of your child for purposes such as celebrating achievements and publicizing education events, as deemed appropriate by teachers and administration. Such use may include display in the district website, Facebook, Edmodo, Google Classroom, and Twitter pages, as well as other educational sites used for instructional purposes. Although the school or classroom may be identified, and that adults appearing in photos/images/videos may be named, your child's name or other personally identifiable information will not be used with any photo/image/video. However, one of the Technology Standards requires students to post their work online, to solicit feedback from a global audience. In situations like this, students may post their names and work, but the postings would be on sites used for educational purposes only.

Pursuant to N.J.S.A. 18A:36-35, the Hillside Public Schools will not release any personally identifiable information without consent from a parent/guardian. By definition from the State, personally identifiable information includes student names, photo or image, residential addresses, email address, phone numbers, and locations/times of class trips. Potential dangers associated with the posting of personally identifiable information on a website exist, since global access to the Internet does not allow us to control who may access such information. As you may know, any photos/images/videos posted on any web site can be downloaded and reprinted by various news organizations, including print, electronic and broadcast media. Therefore, the BOE is released from any liability arising from use of your child's photos/images/videos.

If you object to this agreement and wish to opt out of having your child complete digital work, use internet devices in the classroom, do not want your child to be photographed, and do not wish for an image of your child to be published, you have the right to opt out. You may do so by submitting the below form and indicating that you do not grant permission for your child's name, photograph, or any other personal identifiers to be published on any of the above mentioned websites. Additionally, you may do so at any time by writing a letter to the principal of your child's school indicating that you have rescinded your consent. Emails, voicemails, and verbal requests will not be accepted. In the event your child fails to return the required form, they will not be permitted to participate in the Digital Learner program.

IMPORTANT- PLEASE READ

Digital Learner Release &
Opt Out Message

Background:

In order to be an effective institution of educational opportunity, The Hillside Public Schools is proud to announce that we have gone digital. We have adopted Google Apps for Education, which is a suite of programs that will allow our students to learn, create, research, present, and construct their own knowledge through collaboration on both local and global levels.

The rigorous Technology Standards[1] set forth by The State of New Jersey in 2014 have provided us with guidelines that have helped to broaden our learning opportunities and approach education through a global lens. Our goal is to give students every opportunity to develop a skill set that will serve them well in any career, and provide them with the foundation needed to be successful in positions that have not even been created yet.

Students are expected to collaborate with classrooms from around the world, choose their own learning paths, construct their own knowledge, and gather feedback from others to improve upon their ideas. We have developed a plan to harness the power of the internet, with the main objective always being to provide students with every learning opportunity, while trying our best to protect our students from inappropriate content.

Our Program:

From first grade and up, all students will be issued their own district email accounts. Student accounts will also be created on educational websites, which will help our students meet the Technology Standards. We have researched and compiled a collection of over 700 educational sites which will support our vision of having all students technology literate by the end of 8th grade.

Students 13 and under need parental permission to use sites that require a user to create an account. Creating accounts will allow your child to save his/her work and progress, collaborate with others, and create and share their work with their peers. Signing the form provided below indicates that you have read this message and grant permission for The Hillside Public Schools to create educational accounts for your child. In addition, your child may post his/her work for feedback, where age appropriate, in accordance with the standards.

---

[1] "New Jersey Student Learning Standards - State.NJ.us." 2014. 10 Jun. 2016 <http://www.state.nj.us/education/cccs/2014/tech/>

IMPORTANT- PLEASE READ

Please check one of the following choices:

☐ I/We GRANT permission for my child's name/photo/image and all other personal identifiers to be published on the school/district's public Internet sites and any other form of print/electronic media and/or print/electronic outlets utilized by the District, including those sites used as part of the Digital Learner program.

☐ I/We DO NOT GRANT permission for the use of my child's name/image in any print or electronic media, including the Internet. I understand that this does not include the use of my child's name/image in school-distributed materials, such as programs for performances, yearbook, or school newspapers.

Student's Name (please print)_____School _____GR__

Signature of Parent/Caregiver or Student if over 18 years old _____

Relationship to Student_____Date_____

The consent is valid for one school year and such consent must be obtained on a yearly basis. If you wish to rescind this agreement, you may do so at any time in writing by sending a letter to the principal of your child's school, and such rescission takes effect upon receipt by the school.

If you have any questions about our plans to expand the educational technology opportunities for our students, don't hesitate to contact Kristy Weaver, Educational Data Specialist (908) 352-7664 x6709 or kweaver@hillsidek12.org

HILLSIDE PUBLIC SCHOOLS
TRANSPORTATION APPLICATION
(Grades Pre-K to 1 only)

Student Name: _____ Grade (2019-2020): _____

Address: _____

Date of Birth: _____ Home Phone Number _____

Mother/Guardian Name: _____

Mother/Guardian Cell Phone Number: _____

Mother/Guardian Business Phone: _____

Father/Guardian Name: _____

Father/Guardian Cell Phone Number: _____

Father/Guardian Business Phone Number: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Parent/Guardian Signature: _____ Date: _____

Please check off bus stop preference. *(Please note the school district reserves the right to assign bus stops based on proximity to the student's home.)*

- ☐ Calvin Coolidge
- ☐ Hurden Looker
- ☐ George Washington
- ☐ Walter O. Krumbiegel

ATTENTION PARENT/GUARDIAN: The preparticiaption 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 keeps 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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ 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: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ 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

_____

_____

_____

_____

_____

_____

_____

_____

_____

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 _____

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 _____ 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 _____

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

NOTE: The preparticiaption physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practician 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

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 ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ 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[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]		
Skin • 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		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]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 _____

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 _____

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

EVALUACIÓN FÍSICA – PRE-PARTICIPACIÓN

FORMULARIO DE HISTORIAL MÉDICO

(Nota: Este formulario debe ser rellenado por el paciente y padre/madre antes de ver al doctor. El doctor debe mantener este formulario en el expediente)

Fecha del examen _____

Nombre _____ Fecha de nacimiento _____

Sexo _____ Edad _____ Grado _____ Escuela _____ Deporte(s) _____

Medicamentos y Alergias: Por favor, indica todos los medicamentos con y sin receta médica y suplementos (herbales y nutricionales) que estás tomando actualmente

_____

_____

_____

Tienes alergias ☐ Sí ☐ No Si la respuesta es sí, por favor identifica abajo la alergia específica.
☐ Medicamentos ☐ Polen ☐ Comida ☐ Picaduras de insecto

Explica abajo las preguntas respondidas con un "sí". Pon un círculo alrededor de las preguntas cuyas respuestas desconoces.

PREGUNTAS GENERALES	Sí	No
1. ¿Alguna vez un doctor te ha prohibido o limitado tu participación en deportes por alguna razón?		
2. ¿Tienes actualmente alguna condición médica? Si es así, por favor identifícala abajo: ☐ Asma ☐ Anemia ☐ Diabetes ☐ Infecciones Otro: _____		
3. ¿Has sido ingresado alguna vez en el hospital?		
4. ¿Has tenido cirugía alguna vez?		
PREGUNTAS SOBRE LA SALUD DE TU CORAZÓN	**Sí**	**No**
5. ¿Te has desmayado alguna vez o casi te has desmayado DURANTE o DESPUÉS de hacer ejercicio?		
6. ¿Has tenido alguna vez molestias, dolor o presión en el pecho cuando haces ejercicio?		
7. ¿Alguna vez has sentido que tu corazón se acelera o tiene latidos irregulares cuando haces ejercicio?		
8. ¿Te ha dicho alguna vez un doctor que tienes un problema de corazón? Si es así, marca el que sea pertinente ☐ Presión alta ☐ Un soplo en el corazón ☐ Nivel alto de colesterol ☐ Una infección en el corazón ☐ Enfermedad de Kawasaki ☐ Otro:		
9. ¿Alguna vez un doctor te ha pedido que te hagas pruebas de corazón? (Por ejemplo, ECG/EKG, ecocardiograma)		
10. ¿Te sientes mareado o te falta el aire más de lo esperado cuando haces ejercicio?		
11. ¿Has tenido alguna vez una convulsión inexplicable?		
12. ¿Te cansas más o te falta el aire con más rapidez que a tus amigos cuando haces ejercicio?		

PREGUNTAS SOBRE LA SALUD DEL CORAZÓN DE TU FAMILIA	Sí	No
13. ¿Has tenido algún familiar que ha fallecido a causa de problemas de corazón o que haya fallecido de forma inexplicable o inesperada antes de la edad de 50 años (incluyendo ahogo, accidente de tráfico inesperado, o síndrome de muerte súbita infantil)?		
14. ¿Sufre alguien en tu familia de cardiomiopatía hipertrófica, síndrome Marfan, cardiomiopatía arritmogénica ventricular derecha, síndrome de QT corto, síndrome de Brugada, o taquicardia ventricular polimórfica catecolaminérgica?		
15. ¿Alguien en tu familia tiene problemas de corazón, un marcapasos o un desfibrilador implantado en sucorazón?		
16. ¿Ha sufrido alguien en tu familia un desmayo inexplicable, convulsiones inexplicables, o casi se ha ahogado?		
PREGUNTAS SOBRE HUESOS Y ARTICULACIONES	**Sí**	**No**
17. ¿Alguna vez has perdido un entrenamiento o partido porque te habías lesionado un hueso, músculo, ligamento o tendón?		
18. ¿Te has roto o fracturado alguna vez un hueso o dislocado una articulación?		
19. ¿Has sufrido alguna vez una lesión que haya requerido radiografías, resonancia (MRI) tomografía, inyecciones, terapia, un soporte ortopédico/tablilla, un yeso, o muletas?		
20. ¿Has sufrido alguna vez una fractura por estrés?		
21. ¿Te han dicho alguna vez que tienes o has tenido una radiografía para diagnosticar inestabilidad del cuello o inestabilidad atlantoaxial? (Síndrome de Down o enanismo)		
22. ¿Usas regularmente una tabilla/soporte ortopédico, ortesis, u otro dispositivo de asistencia?		
23. ¿Tienes una lesión en un hueso, músculo o articulación que te esté molestando?		
24. ¿Algunas de tus articulaciones se vuelven dolorosas, inflamadas, se sienten calientes, o se ven enrojecidas?		
25. ¿Tienes historial de artritis juvenil o enfermedad del tejido conectivo?		

(Por favor, continúe)

PREGUNTAS MÉDICAS	Sí	No
26. ¿Toses, tienes sibilidos o dificultad para respirar durante o después de hacer ejercicio?		
27. ¿Has usado alguna vez un inhalador o has tomado medicamento para el asma?		
28. ¿Hay alguien en tu familia que tenga asma?		
29. ¿Naciste sin o te falta un riñón, un ojo, un testículo (varones), el bazo, o algún otro órgano?		
30. ¿Tienes dolor en la ingle o una protuberancia o hernia dolorosa en el área de la ingle?		
31. ¿Has tenido mononucleosis (mono) infecciosa en el último mes?		
32. ¿Tienes algún sarpullido, llagas, u otros problemas en la piel?		
33. ¿Has tenido herpes o infección de SARM en la piel?		
34. ¿Has sufrido alguna vez una lesión o contusión en la cabeza?		
35. ¿Has sufrido alguna vez un golpe en la cabeza que te haya producido una confusión, dolor de cabeza prolongado, o problemas de memoria?		
36. ¿Tienes un historial de un trastorno de convulsiones?		
37. ¿Tienes dolores de cabeza cuando haces ejercicio?		
38. ¿Has tenido entumecimiento, hormigueo, o debilidad en los brazos o piernas después de haber sufrido un golpe o haberte caído?		
39. ¿Has sido alguna vez incapaz de mover los brazos o las piernas después de haber sufrido un golpe o haberte caído?		
40. ¿Te has enfermado alguna vez al hacer ejercicio cuando hace calor?		
41. ¿Tienes calambres frecuentes en los músculos cuando haces ejercicio?		
42. ¿Tienes tú o alguien en tu familia el rasgo depranocítico o la enfermedad drepanocítica?		
43. ¿Has tenido algún problema con los ojos o la vista?		
44. ¿Has sufrido alguna lesión o daño en los ojos?		
45. ¿Usas lentes o lentes de contacto?		
46. ¿Usas protección para los ojos, tal como lentes protectoras o un escudo facial?		
47. ¿Te preocupa tu peso?		
48. ¿Estás intentando aumentar o perder de peso o alguien te ha recomendado que lo hagas?		
49. ¿Estás siguiendo alguna dieta especial o evitas ciertos tipos de comida?		
50. ¿Has tenido alguna vez un trastorno alimenticio?		
51. ¿Tienes alguna preocupación de la que quieras hablar con el doctor?		

SÓLO PARA MUJERES	Sí	No
52. ¿Has tenido alguna vez el período menstrual?		
53. ¿Qué edad tenías cuando tuviste tu primer período menstrual?		
54. ¿Cuántos períodos has tenido en los últimos 12 meses?		

Explica aquí las preguntas a las que respondiste con un "sí"

Yo por la presente declaro que, según mi más leal saber y entender, mis respuestas a las preguntas anteriores están completas y son correctas.

Firma del atleta _____

Firma del padre/madre/tutor legal _____

Fecha _____

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