



Athletic Participation Information 2026-2027
Alexis Sellers, Athletic Director - sellersa@wctech.org
David Nicholson, Athletic Trainer - nicholsond@wctech.org

All forms should be submitted to the main office or emailed to the Athletic Trainer by the appropriate date.

1. **Sports Physicals:** To play a sport, a physical must be completed every 365 days. The physical must still be valid on the first day of practice for it to be valid for that sport season.

For New Jersey sports physical paperwork, **the school only receives and keeps the Athletic Participation Clearance Form (Page 4)**. The student's **doctor's office is responsible for keeping Pages 1–3** of the physical packet. Sports physical packet: [NJ Athletic Physical Forms](#).

Example:

If soccer practice starts on August 15, 2026, the sports physical must be dated between August 15, 2025, and August 15, 2026. A physical completed before August 15, 2025, would be expired and your child would not be able to participate until a new physical is submitted.

2. In addition, a [Health History Update Questionnaire](#) must be completed every 90 days from the date of the physical to continue participating in sports.

3. ALL forms must be reviewed by the parent/guardian and student-athlete. Most forms can be found in Genesis under the parent account titled 2026-2027 Athletic Acknowledgement Forms. If you need a hard copy of the forms, please email Mrs. Sellers.

- Concussion Fact Sheet
- Sudden Cardiac Death Pamphlet
- Opioid Use/Misuse Fact Sheet
- NJSIAA Steroid Testing & Consent Form
- HIPAA Form
- Consent to Treat Form
- Medical Release Form (hard copy only in this packet)

4. A student-athlete must complete the IMPACT test prior to competing in Athletics. Instructions for the IMPACT test are included in this packet.
5. Parents/Guardians of athletes must complete the Spectator Code of Conduct form in order to attend events at Warren Tech.
6. All athletic forms must be completed in Genesis and/or handed in (sports physicals/health history update) to the main office or Athletic Trainer by the designated due date.

Paperwork Due Date for Each Season:

Fall: July 30, 2026
Winter: October 13, 2026
Spring: February 23, 2027



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**Warren County Technical School Coach's
 Medical Release Form**

Player's Name: _____

Address: _____

Date of Birth: _____

Sex: _____

Parent/Guardian Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Alternate Emergency Contact: _____

Relationship to Athlete: _____

Phone Number: _____

Insurance Coverage: _____

Insurance Name: _____

Name of Policy Holder: _____

Relationship to Athlete: _____

Policy #: _____

Group #: _____

Primary Care Physician: _____

Phone #: _____

Please list any know allergies or pertinent medical information:

Do you have an EpiPen? Yes No

Do you have an inhaler? Yes No

Parent/Guardian Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Realizing that such activity involves the potential for injury, which is inherent in all sports, I, Parent/Guardian, acknowledge that even the best coaching, use of the most advanced protective equipment, and strict observance of rules, injuries are still possible. On rare occasions, these injuries can be severe enough to result in complete or partial paralysis or even death. In the event that the above-named student is presented for or requires medical treatment, I, parent/legal guardian, acknowledge that I/We have read and understand this warning. Therefore, I grant Coach(s) and/or Athletic Trainer permission to act as my surrogate for my child in the area of obtaining treatment from a doctor of medicine or dentistry. I also assume the financial responsibility for any medical treatment of my child.

Signature of Parent/Guardian: _____

Date: _____

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student - Athlete Cardiac Assessment Professional Development module Hosted by the New Jersey Department of Education.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)
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, e-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-enhancing 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 (Q4-Q13 of History Form).

EXAMINATION			
Height:	Weight:		
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N	
COVID-19 VACCINE			
Previously received COVID-19 vaccine: <input type="checkbox"/> Y <input type="checkbox"/> N			
Administered COVID-19 vaccine at this visit: <input type="checkbox"/> Y <input type="checkbox"/> N If yes: <input type="checkbox"/> First dose <input type="checkbox"/> Second dose <input type="checkbox"/> Third dose <input type="checkbox"/> Booster date(s) _____			
MEDICAL		NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)			
Eyes, ears, nose, and throat • Pupils equal • Hearing			
Lymph nodes			
Heart • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)			
Lungs			
Abdomen			
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis			
Neurological			
MUSCULOSKELETAL		NORMAL	ABNORMAL FINDINGS
Neck			
Back			
Shoulder and arm			
Elbow and forearm			
Wrist, hand, and fingers			
Hip and thigh			
Knee			
Leg and ankle			
Foot and toes			
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test			

* Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____
 Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

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■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): Y N

Have you been immunized for COVID-19? (check one): Y N If yes, have you had: One shot Two shots
 Three shots Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥ 3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS

(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)

	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		

HEART HEALTH QUESTIONS ABOUT YOU

	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU

(CONTINUED)

	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

	Unsure	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The Medical Eligibility Form is the only form that should be submitted to a school.

■ PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: _____ Date of birth: _____

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or 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 as having 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 whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (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 questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

Preparticipation Physical Evaluation Medical Eligibility Form

The Medical Eligibility Form is the only form that should be submitted to school. It should be kept on file with the student's school health record.

Student Athlete's Name _____ Date of Birth _____

Date of Exam _____

- Medically eligible for all sports without restriction
- Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of
- Medically eligible for certain sports
- Not medically eligible pending further evaluation
- Not medically eligible for any sports

Recommendations: _____

I have reviewed the history form and examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings- are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Signature of physician, APN, PA _____ Office stamp (optional)

Address: _____

Name of healthcare professional (print) _____

I certify I have completed the Cardiac Assessment Professional Development Module developed by the New Jersey Department of Education,

Signature of healthcare provider _____

Shared Health Information

Allergies _____

Medications:

Other information: _____

Emergency Contacts: _____

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*This form has been modified to meet the statutes set forth by New Jersey.

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

At Home Instructions

AT-HOME CONCUSSION IMPACT BASELINE TESTING EXPLANATION AND INSTRUCTIONS

As part of the concussion evaluation, St. Luke's University Health Network uses a computerized assessment measure called IMPACT (Immediate Post-Concussion Assessment and Cognitive Testing) to aid in the clinical decision-making process. IMPACT is a computerized neuropsychological assessment of memory, attention, reaction time, processing speed, and post-concussion symptoms. IMPACT provides specific, objective information regarding the injury. IMPACT is only one tool in the multidisciplinary approach to the concussion evaluation. To properly assess post-injury IMPACT results, a baseline IMPACT test must be on file. These tests are regarded as privileged medical information and results are not shared with anyone besides the medical staff, unless requested by your child's treating physician.

AT HOME BASELINE TESTING

The test takes approximately 30-40 minutes to complete. If your school/organization is performing at home IMPACT testing, please read the instructions carefully, as the validity of the IMPACT test depends on them. If you have any questions or need further instruction, please reach out to your athletic trainer.

REMINDERS

When taking the IMPACT baseline test, the environment should be similar to how the athlete would take a post-injury test, should a concussion be suspected or need to be ruled out. To help create this standardization, please follow these instructions:

1. The test should be taken in a quiet, distraction-free environment. This means no earbuds, no cellphone use, etc... during the test.
2. The test should be taken on a computer. If taken on a laptop, do not use the trackpad, instead, **PLEASE USE THE MOUSE.**
3. Be sure to have a secure Internet/WIFI connection.
4. If applicable, the test should be completed before any strenuous exercise or at least 3 hours after strenuous exercise.

If your code will not work, enable pop-ups on your browser. If your test freezes for more than one minute, try refreshing your page. If this does not work, you will have to restart the test. If you do not have a strong WIFI connection, consider using an Ethernet cable or taking the test on a desktop if possible. If a baseline test is deemed invalid, the athletic trainer will have the athlete retake the test.

Part of the test relies on seeing colors. If your child has a color vision deficiency or color blindness and you think it will alter the results of the test, please email the athletic trainers, as we use an alternate baseline concussion test.

STARTING THE IMPACT TEST

1. Open your browser, enter the website:
www.impacttestonline.com/testing
2. Warren Tech Access Code. **AZV8QSNXT**
3. Click **VALIDATE**
4. Click the box **SELECT AN ORGANIZATION** and scroll down until you see the name of your school/organization.
5. Click **LAUNCH BASELINE TEST**
6. The test has now started.
 1. When you get to the slide that asks if you would like to skip or enter demographic, click **ENTER DEMOGRAPHICS.**
 2. Give your best answer for **CURRENT POSITION/EVENT/CLASS** (ie. point guard in basketball, swimming event(s), flyer/base in cheer, wrestling weight class).

WHEN YOU HAVE FINISHED THE TEST

1. You will see a screen with your information on it and a spot on the bottom to enter your email.
2. Enter an email you have access to. That email will get a copy of the athlete's passport ID.
3. The screen will not change, simply close the browser.