Dear Parents/Guardians,

Please review the important medical and athletics information below for the 2026–2027 school year:

Bergen Catholic requires annual physicals and updated immunization records for **ALL** students in every grade level, regardless of athletic participation.

Medical forms can be downloaded from the Bergen Catholic website under:
Athletics → Medical Forms

All student-athletes participating in Fall sports must:

- Register on ArbiterSports using the 2026–2027 school year
    - Deadline June 15, 2026
- Upload all completed physical forms to ArbiterSports
    - Deadline July 24, 2026
- Have a physical completed within 365 days of the official start date

Physicals for all students should be submitted by the first week of school.

In addition to uploading forms to ArbiterSports, hard copies of all completed physical paperwork must also be submitted directly to the Nurse's Office.

If your son requires medication during school hours, a completed medication authorization form signed by the physician must be on file with the Nurse's Office. Medication cannot be administered without this form.

Holy Name Medical Center is offering free physicals for Bergen Catholic student-athletes. To schedule an appointment, please call (201) 833-3042 and indicate that you are a Bergen Catholic student-athlete.

Thank you,

Brendan McGovern
Director of Athletics
bmcgovern@bergencatholic.org

M. Celeste Tumino, RN, BSN, CSN
School Nurse
ctumino@bergencatholic.org
201-634-2216

Michael Vankoppen, Athletic Trainer
mvankoppen@holyname.org
201-261-1844 ext. 148

Billy Cook, Athletic Trainer
wcook@holyname.org

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)

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?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

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: _____

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: _____

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■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

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, 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?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N		
Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ 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[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (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		

[a] 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

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 _____

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

**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

New Jersey School (K-12) Vaccine Requirements

New Jersey requires children attending school to meet minimum immunization requirements. These vaccines help protect children from serious illnesses that can easily spread in group settings, where they are in close contact with one another. For the best protection, children should follow the AAP childhood schedule.

The table below shows the number of vaccine doses required based on the child's grade of entry. Fewer doses may be needed than what is listed if the child is behind schedule. Talk to your child's doctor for details.

	Kindergarten/Grade 1 (Entry Grade)	**Grades 2-6**	**Grades 7-12**
DTaP (for children under age 7) **Td/Tdap** (for children 7 and older)	**Primary Series:** 4 or 5 doses (at least one dose on or after the 4th birthday)	Proof of completing primary series (at least one dose on or after the 4th birthday)	Proof of completing primary series **AND** at least 1 Tdap at age 10 or older.
IPV/OPV	Total of 3 or 4 doses (at least one dose given on or after the 4th birthday)		
MMR	Total of 2 doses		
VAR	Total of 1 dose		
Hep B	Total of 3 doses (or an approved two-dose series)		
Men ACWY	None	None	Total of 1 dose which must be given at age 10 and older

Vaccine Key

DTaP: Diphtheria, Tetanus, and Pertussis (whooping cough)

Td: Tetanus and diphtheria

Tdap: Tetanus, diphtheria, pertussis

IPV/OPV: Inactivated Polio Vaccine and Oral Polio Vaccine

MMR: Measles, Mumps, and Rubella

VAR: Varicella

Hep B: Hepatitis B

MenACWY: Meningococcal ACWY

NJ Health New Jersey Department of Health

March 2026

This is a summary document. New Jersey's minimum immunization requirements are based on the American Academy of Pediatrics (AAP), AAP childhood schedule. Vaccines are required at the earliest age of school entry. Children who are not up to date with the required vaccines will be required to follow the catch-up immunization schedule; parents should speak to their health care provider to help their children get caught up.

Medical and religious exemptions (reasons for not receiving vaccines) are detailed in the Immunization of Children in Child Care Centers and Schools regulations. Instructions for viewing the regulations are available at nj.gov/health/cd/imm_requirements/acode/. Another resource is the "NJ Immunization Requirements Frequently Asked Questions", available at nj.gov/health/cd/imm_requirements/.

***DTaP/Td/Tdap**

Kindergarten or Grade 1: By the time children start school, they need 4 or 5 DTaP doses, depending on their age when they began the vaccination series. At least one dose must be given on or after their 4th birthday.

Grades 2–6: A primary series means completing all the beginning doses of a vaccine. Children age 7 or older who are not up to date need to either finish their Td/Tdap vaccine series or show they have already had at least 3 total doses of DTaP, Td, or Tdap with one dose on or after the 4th birthday. Your health care provider can help your child get caught up by using the catch-up schedule.

Grades 7 and higher: Students must have one Tdap dose given at age 10 or older and show proof that they completed the primary series.

Kindergarten through grade 12

IPV/OPV: OPV is not recommended for use, nor is it available in the United States. However, OPV may be utilized in other countries. Doses are only accepted if given before April 2016. Children who receive OPV doses after April 2016 must receive IPV doses instead. At least one dose must be given on or after their 4th birthday. Previously polio vaccine doses were not required for those 18 years of age an older; however, those 18 and older must now meet the requirements for school attendance.

MMR: Two doses of measles, mumps, and rubella.

Varicella: One dose of varicella is required. Two doses are recommended by AAP, but not required for school attendance.

Hep B: 3 doses or an approved two-dose series.

Meningococcal ACWY: One dose of MenACWY is required for those ages 10 and older at grade 7 and higher. Doses of MenACWY given before age 10 would need to be repeated.

Bergen Catholic High School Emergency/Illness/Accident Form

Student Name:_____

Student's Graduation Year:_____

Parent/Guardian's Name(s):_____

Parent/Guardian's Cell Phone_____

Parent/Guardian's Cell Phone_____

Allergies_____

Medical Conditions_____

_____

Permission for the student to take generic medication for antacid/pain-reliever

Yes:_____ **No:**_____

Name/Number of Medical Provider:_____

Parent/Guardian Signature:_____

NURSE ADMINISTRATION OF MEDICATION IN SCHOOL

NAME OF STUDENT_____ **GRADE**_____

DIAGNOSIS_____

MEDICATION_____

DOSAGE_____ **FREQUENCY**_____

DIRECTIONS_____

POSSIBLE SIDE EFFECTS_____

I authorize the School Nurse to administer the above medication:

Signature of M.D. **Date**	**Signature of Parent/Guardian** **Date**
Physician's Street Address	**Town & Zip Code**
Telephone Number	

SELF-ADMINISTRATION OF MEDICATION IN SCHOOL

I certify that this student has asthma or another potentially life-threatening illness and is permitted to self-administer the above medication. He/she has been instructed in the proper techniques of self-administration and has demonstrated competence in this technique.

Signature of Prescribing Physician	**Date**
Address	**Telephone Number**

I authorize my child to self-administer the above medication. This permission includes self-administration of medication during regular school hours and at other times when my child is participating in a school-related event. I understand that the district, school, school nurse and other school employees shall incur no liability as a result of any injury arising from the self-administration of this medication and that I will indemnify and hold harmless the district, school, school nurses and other school employees against any claims arising from the self-administration of the medication by my child.

Date_____**Parent/Guardian Signature**_____

BOTTOM PORTION OF THIS FORM TO BE FILLED OUT ONLY IF STUDENT SELF-MEDICATES.