

# Athletic Physical Form Check List

(Athlete and parents need to follow each step. Do not skip a step.)

**\*\*Please read carefully as participation rules have changed for 2016-2017 school year**

Step 1 \_\_\_\_\_ Pick up a physical form packet from the Head Coach/  
Nurse's Office/Athletic Trainer's Office/print online  
<http://www.metuchenschools.org>(under athletic tab,  
then forms)

Step 2 \_\_\_\_\_ Take forms home and have Guardian/Parent(s) and  
Athlete fill out each section.

Step 3 \_\_\_\_\_ Make an appointment to get a physical with your doctor  
or with the school nurse to have the physical done by  
the school physician

**\*\*\*Take note of school deadlines or the parent will be responsible for taking the forms to  
the team physician for clearance. No exceptions.**

Step 4 \_\_\_\_\_ Bring ALL **completed** forms to School Nurse (hand delivered), not the coach or  
athletic trainer (including forms for inhaler and/or EpiPen and proof of **completed  
impact test-incomplete packets will not be accepted**). Packets left in the  
school nurse's mailbox **will not be accepted**.

Step 5 \_\_\_\_\_ Nurse will make sure everything is complete. Then, the Nurse will submit  
physical forms to the School Doctor for approval (only if done by a physician  
other than school). **If submitted after school deadline, parent/guardian will be  
responsible for taking forms to Dr. Lukenda's office: 850 N. Wood Avenue,  
Linden, NJ (908-925-9309). ALL physicals need to be cleared by Dr.  
Lukenda**

Step 6 \_\_\_\_\_ List of athletes goes to the head coach (if you are on the  
list, then you are eligible to participate).

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Student Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

**METUCHEN HIGH SCHOOL**  
**DEPARTMENT OF ATHLETICS**  
400 Grove Avenue  
Metuchen, New Jersey 08840

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**SPORT PHYSICALS**

Dear Parents/Guardians:

All students are required by law to complete the N.J. Department of Education Health History Questionnaire and Physical Evaluation Form in order to participate in inter-scholastic sports. If a student does not have access to health care, that student can arrange to be examined by the school physician by notifying the school nurse; only the N.J. Department of Education athletic pre-participation physical forms will be accepted.

Please adhere to the following guidelines:

- A physical will cover the student-athlete for 365 days. **If the physical expires during the course of the season, your child will need a new physical before participating the next season. \* \* The parent/guardian is responsible for keeping track of the physical examination date.**
- **The Health History Questionnaire is required to be reviewed by your health care provider (HCP) at the time of your exam. Please remember to bring this form, completed, with you to your appointment.**
- If the student-athlete needs medication in order to participate in sports, such as an Epi-Pen, the medication form will need to be completed by the HCP and the parent/guardian (see School Nurse).
- If your child has been diagnosed with asthma and carries an inhaler, then **you and your primary physician must fill out the "Asthma Treatment Plan" (see attached). This form is good for one school year.**
- **Permission slips and the Health History Questionnaire must be dated within 60 days of the first day of official practice.**
- Use the Sport Physical Checklist to ensure that all required paperwork is completed.

**Please return all medical forms to the School Nurse.** This will allow our school nurse and the school physician to review all paperwork, so that your child will be eligible to participate in the first official practice of the season. Please note new guidelines and deadlines regarding the athletic packet being returned to the school nurse. **Failure to return all necessary documents will delay your child's ability to start practicing on the first day of official practice.**

# **SPORT PHYSICAL CHECKLIST**

- \_\_\_\_\_ Part A: Health History Questionnaire  
(Completed by Parent/Guardian and reviewed by physician)
- \_\_\_\_\_ Part B: Physical Examination Form is completed and signed by the  
Health Care Provider  
(To be completed every 365 days)
- \_\_\_\_\_ Completed Asthma Treatment Plan with Primary Physician signature  
(**\*\*\*only if athlete has been diagnosed with  
asthma and carries an inhaler**)
- \_\_\_\_\_ **Athletes Name Filled in** on Pre-Participation Forms  
(Parent and Athletic Trainer Notification Forms)
- \_\_\_\_\_ Signed M.H.S. Athletic Parental Consent Form
- \_\_\_\_\_ Signed School Insurance Information Form
- \_\_\_\_\_ Impact Testing Information and Code Sheet **to be completed at  
home and proof of impact test to be handed in with packet**
- \_\_\_\_\_ Signed NJSIAA Steroid Testing policy, Concussion Policy Form, and  
Sudden Cardiac Death Pamphlet
- \_\_\_\_\_ Review Sudden Cardiac Death in Youth Athletes Information  
Brochure  
(**Detach for your reference**)
- \_\_\_\_\_ Review MRSA Skin Infection Information Brochure  
(**Detach for your reference**)

**Packets will not be accepted if not stapled, in order and  
complete with name on it.**

ATTENTION PARENT/GUARDIAN: The preparticipation 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 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

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 \_\_\_\_\_

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

9-28810/0710

# **PREPARTICIPATION PHYSICAL EVALUATION THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM**

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

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

NOTE: The preparticipation physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practitioner, 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
<b>MEDICAL</b>		<b>NORMAL</b>	<b>ABNORMAL FINDINGS</b>
Appearance <ul style="list-style-type: none"> <li>Marian stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperflexity, myopia, MVP, aortic insufficiency)</li> </ul>			
Eyes/ears/nose/throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>			
Lymph nodes			
Heart* <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, supine, +/- Valsalva)</li> <li>Location of point of maximal impulse (PMI)</li> </ul>			
Pulses <ul style="list-style-type: none"> <li>Simultaneous femoral and radial pulses</li> </ul>			
Lungs			
Abdomen			
Genitourinary (males only)*			
Skin <ul style="list-style-type: none"> <li>HSV, lesions suggestive of MRSA, tinea corporis</li> </ul>			
Neurologic*			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional <ul style="list-style-type: none"> <li>Duck-walk, single leg hop</li> </ul>			

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

\*Consider GI exam if in private setting. Having third party present is recommended.

\*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 \_\_\_\_\_

# Asthma Treatment Plan – Student Parent Instructions



The PACH Asthma Treatment Plan is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. **Parents/Guardians:** Before taking this form to your Health Care Provider, complete the top left section with:
  - Child's name
  - Child's doctor's name & phone number
  - Parent/Guardian's name & phone number
  - Child's date of birth
  - An Emergency Contact person's name & phone number
2. **Your Health Care Provider** will complete the following areas:
  - The effective date of this plan
  - The medicine information for the Healthy, Caution and Emergency sections
  - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
  - Your Health Care Provider may check "OTHER" and:
    - ✦ Write in asthma medications not listed on the form
    - ✦ Write in additional medications that will control your asthma
    - ✦ Write in generic medications in place of the name brand on the form
  - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow
3. **Parents/Guardians & Health Care Providers** together will discuss and then complete the following areas:
  - Child's peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
  - Child's asthma triggers on the right side of the form
  - Permission to Self-administer Medication section at the bottom of the form: Discuss your child's ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form
4. **Parents/Guardians:** After completing the form with your Health Care Provider:
  - Make copies of the Asthma Treatment Plan and give the signed original to your child's school nurse or child care provider
  - Keep a copy easily available at home to help manage your child's asthma
  - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

## PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child's health care provider concerning my child's health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

Parent/Guardian Signature \_\_\_\_\_

Phone \_\_\_\_\_

Date: \_\_\_\_\_

**FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.**

**RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY**

☐ I do request that my child be **ALLOWED** to carry the following medication \_\_\_\_\_ for self-administration in school pursuant to N.J.A.C. 8A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ I **DO NOT** request that my child self-administer his/her asthma medication.

Parent/Guardian Signature \_\_\_\_\_

Phone \_\_\_\_\_

Date \_\_\_\_\_



METUCHEN SCHOOL DISTRICT

PARENTAL ATHLETIC CONSENT AND AGREEMENT 20 - 20

(Must be completed and returned to the Athletic Department before athletic participation)

NAME \_\_\_\_\_ GRADE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

FALL SPORT(S) \_\_\_\_\_ WINTER \_\_\_\_\_

SPRING \_\_\_\_\_

BY SIGNING THIS AGREEMENT I AM ACKNOWLEDGING THAT I HAVE REVIEWED AND WILL ABIDE BY THE FOLLOWING:

1. SCHOOL INSURANCE INFORMATION FORM
2. NJSIAA POLICY AND CONSENT TO RANDOM STEROID TESTING/BANNED DRUG CLASS
3. CONCUSSION POLICY AND CONSENT TO IMPACT TESTING
4. "SUDDEN CARDIAC DEATH IN YOUNG ATHLETES" INFORMATIONAL PAMPHLET
5. MRSA INFORMATIONAL PAMPHLET

I hereby certify that I have reviewed the policies above and it is with my full knowledge and consent that my child participate in the above named sport and he/she will abide by the rules and policies set forth by the Metuchen Board of Education and the NJSIAA.

I hereby give consent to my son/daughter to participate in the above listed interscholastic sports program during the above listed school year, realizing that such activity involves the potential for injury that is inherent in all sports. I/we acknowledge that even with the best coaching, use of the most advanced protective equipment and strict observance of school rules, injuries are still a possibility. On rare occasions these injuries can be so severe as to result in total disability, paralysis or even death. I/we acknowledge that I/we have read and understand this warning. Further, I/we will not hold Metuchen High School Board of Education, or its representatives responsible in any way for injuries that may occur to my son/daughter because of his/her participation in the sport listed above. In the case of injury, the athletic trainer, coach, school nurse or administrator has my permission to have him/her treated at the nearest hospital if I cannot be reached.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Name (PRINTED) \_\_\_\_\_

Address: \_\_\_\_\_

Mother Cell Phone # \_\_\_\_\_ Father Cell Phone # \_\_\_\_\_

Mother Work # \_\_\_\_\_ Father Work # \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_ Insurance ID# \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_



## METUCHEN HIGH SCHOOL

400 GROVE AVENUE  
METUCHEN, NEW JERSEY 08840

(732) 321-8744  
FAX (732) 549-6415

Dear Parents/Guardian:

The Board of Education has purchased insurance coverage to protect all participants in interscholastic athletics against accidental injury. *This policy is excess to your personal medical insurance. Therefore, this will take effect only after all medical bills are first submitted to your personal medical insurance carrier.*

Please ensure that all injuries, regardless of how minor, are reported immediately to the coach and athletic trainer. The athletic trainer, after receiving information for the injury report, will notify the School Nurse. An accident report will be filed and claim forms will be sent to you by mail. These forms will include instructions on claims reporting procedures through Bollinger Insurance Company. All questions regarding claims procedures should be addressed to the insurance company claims office, not school officials.

Please note that decisions regarding types of treatment and specific physicians to treat any injury rest with you, the parent/guardian. The Metuchen School District makes no recommendations to parents/guardian or students regarding medical facilities or physicians.

*I have read and understand the insurance coverage.*

Date: \_\_\_\_\_ Student participating: \_\_\_\_\_

Sport: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

### Mission Statement

Metuchen High School, building on a tradition of academic and co-curricular distinction, provides a safe and nurturing environment for all students. As an educational cornerstone in our historical, small suburb, we recognize the high expectations of our community. Our curricular offerings are an integral part of an evolving program that meets each student's intellectual, social, and emotional needs.

We are committed to superior classroom instruction and encourage our students to strive for excellence. Our school balances innovative, experiential, and traditional learning, encouraging all students to discover their talents, develop their strengths, and become responsible and



## **NJSIAA STEROID TESTING POLICY AND** **PARENT/GUARDIAN CONCUSSION POLICY** **ACKNOWLEDGMENT FORMS**

### **NJSIAA STEROID TESTING POLICY** **CONSENT TO RANDOM TESTING**

In Executive Order 72, issued December 20, 2005, Governor Richard Codey directed the New Jersey Department of Education to work in conjunction with the New Jersey State Interscholastic Athletic Association (NJSIAA) to develop and implement a program of random testing for steroids, of teams and individuals qualifying for championship games.

Beginning in the Fall, 2006 sports season, any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances on the attached page, without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition. The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing.

# 2014-15 NJSIAA Banned Drugs

**IT IS YOUR RESPONSIBILITY TO CHECK WITH THE APPROPRIATE OR DESIGNATED ATHLETICS STAFF BEFORE USING ANY SUBSTANCE**

The NJSIAA bans the following classes of drugs:

- Stimulants
- Anabolic Agents
- Alcohol and Beta Blockers (banned for rifle only)
- Diuretics and Other Masking Agents
- Street Drugs
- Peptide Hormones and Analogues
- Anti-estrogens
- Beta-2 Agonists

**Note: Any substance chemically related to these classes is also banned.**

**THE INSTITUTION AND THE STUDENT-ATHLETE SHALL BE HELD ACCOUNTABLE FOR ALL DRUGS WITHIN THE BANNED DRUG CLASS REGARDLESS OF WHETHER THEY HAVE BEEN SPECIFICALLY IDENTIFIED.**

## Drugs and Procedures Subject to Restrictions

- Blood Doping
- Local Anesthetics (under some conditions)
- Manipulation of Urine Samples
- Beta-2 Agonists permitted only by prescription and inhalation
- Caffeine if concentrations in urine exceed 15 micrograms/ml

Before consuming any nutritional/dietary supplement product, review the product with the appropriate or designated athletics department staff

- Dietary supplements are not well regulated and may cause a positive drug test result.
- Student-athletes have tested positive and lost their eligibility using dietary supplements.
- Many dietary supplements are contaminated with banned drugs not listed on the label.
- Any product containing a dietary supplement ingredient is taken at your own risk.

**NOTE TO STUDENT-ATHLETES: THERE IS NO COMPLETE LIST OF BANNED SUBSTANCES. DO NOT RELY ON THIS LIST TO RULE OUT ANY SUPPLEMENT INGREDIENT. CHECK WITH YOUR ATHLETICS DEPARTMENT STAFF PRIOR TO USING A SUPPLEMENT.**

## Some Examples of NJSLA Banned Substances in Each Drug Class

### Stimulants

Amphetamine (Adderall); caffeine (guarana); cocaine; ephedrine; fenfluramine (Fen); methamphetamine; methylphenidate (Ritalin); phentermine (Phen); synephrine (bitter orange); methylephedrine, "bath salts" (mephedrone) etc.

exceptions: phenylephrine and pseudoephedrine are not banned.

### Anabolic Agents (sometimes listed as a chemical formula, such as 3,6,17-androstenedione)

Androstenedione; boldenone; clenbuterol; DHEA (7-Keto); epi-trenbolone; etiocholanolone; methasterone; methandienone; nandrolone; norandrostenedione; stanozolol; stanolone; testosterone; trenbolone; etc.

### Alcohol and Beta Blockers (banned for rifle only)

Alcohol; atenolol; metoprolol; nadolol; pindolol; propranolol; timolol; etc.

### Diuretics (water pills) and Other Masking Agents

Bumetanide; chlorothiazide; furosemide; hydrochlorothiazide; probenecid; spironolactone (canrenone); triameterene; trichlormethiazide; etc.

### Street Drugs

Heroin; marijuana; tetrahydrocannabinol (THC); synthetic cannabinoids (eg. spice, K2, JWH-018, JWH-073)

### Peptide Hormones and Analogues

Growth hormone(hGH); human chorionic gonadotropin (hCG); erythropoietin (EPO); etc.

### Anti-Estrogens

Anastrozole; tamoxifen; formestane; 3,17-dioxo-etiochol-1,4,6-triene(ATD), etc.

### Beta-2 Agonists

Bambuterol; formoterol; salbutamol; salmeterol; etc.

**ANY SUBSTANCE THAT IS CHEMICALLY RELATED TO THE CLASS, EVEN IF IT IS NOT LISTED AS AN EXAMPLE, IS ALSO BANNED! IT IS YOUR RESPONSIBILITY TO CHECK WITH THE APPROPRIATE OR DESIGNATED ATHLETICS STAFF BEFORE USING ANY SUBSTANCE.**

Dear Parent/Guardian,

Metchuen High School and Edgar Middle School have implemented an innovative program for our student-athletes. This program will assist our team physicians/athletic trainers in evaluating and treating head injuries (e.g., concussion). In order to better manage concussions sustained by our student-athletes, we have acquired a software tool called ImPACT (Immediate Post Concussion Assessment and Cognitive Testing). ImPACT is a computerized exam utilized in many professional, collegiate, and high school sports programs across the country to successfully diagnose and manage concussions. If an athlete is believed to have suffered a head injury during competition, ImPACT is used to help determine the severity of head injury and when the injury has fully healed.

The computerized exam is given to athletes before beginning contact sport practice or competition. This non-invasive test is set up in "video-game" type format and takes about 15-20 minutes to complete. It is simple, and actually many athletes enjoy the challenge of taking the test. Essentially, the ImPACT test is a preseason physical of the brain. It tracks information such as memory, reaction time, speed, and concentration. It, however, is not an IQ test.

If a concussion is suspected, the athlete will be required to re-take the test. Both the preseason and post-injury test data is given to a local doctor or, to help evaluate the injury. The information gathered can also be shared with your family doctor. The test data will enable these health professionals to determine when return-to-play is appropriate and safe for the injured athlete. If an injury of this nature occurs to your child, you will be promptly contacted with all the details.

I wish to stress that the ImPACT testing procedures are non-invasive, and they pose no risks to your student-athlete. We are excited to have implemented this program given that it provides us the best available information for managing concussions and preventing potential brain damage that can occur with multiple concussions. The Metchuen school district administration, coaching, and athletic training staffs are striving to keep your child's health and safety at the forefront of the student athletic experience. Please return the attached page with the appropriate signatures. If you have any further questions regarding this program please feel free to contact Lauren Butler, Athletic Trainer, at 732-321-8766 or John Cathcart, Athletic Director, at 732-321-8755.

Each student is required to take the ImPACT baseline test AT HOME by logging onto the following website:

[www.impacttestonline.com/schools](http://www.impacttestonline.com/schools)

Organization: Select New Jersey

Use Code: 47CF9105AE

Students will NOT be able to participate in a school based sport without a baseline! Proof of completion must be submitted to athletic trainer or nurse.



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**Consent Form**

For use of the Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT)

I have read the attached information. I understand its contents. I have been given an opportunity to ask questions and all questions have been answered to my satisfaction. I agree to participate in the ImPACT Concussion Management Program.

Metuchen School District may release the ImPACT results to my child's primary care physician, neurologist or other treating physician.

I understand that general information about the test may be provided to my child's guidance counselor and teachers if necessary.

**Printed Name of Athlete** \_\_\_\_\_

**Sport** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Athlete**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent**

\_\_\_\_\_  
**Date**



## NJSIAA PARENT/GUARDIAN CONCUSSION POLICY ACKNOWLEDGMENT FORM

In order to help protect the student athletes of New Jersey, the NJSIAA has mandated that all athletes, parents/guardians and coaches follow the NJSIAA Concussion Policy.

A concussion is a brain injury and all brain injuries are serious. They may be caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. In other words, even a "ding" or bump on the head could be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child/player reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

**Symptoms may include one or more of the following:**

1. Headache
2. Nausea/vomiting
3. Balance problems or dizziness
4. Double vision or changes in vision
5. Sensitivity to light or sound/noise
6. Feeling of sluggishness or foggy
7. Difficulty with concentration, short-term memory, and/or confusion
8. Irritability or mood changes
9. Depression or anxiety
10. Sleep Disturbance

**Signs observed by teammates, parents and coaches include:**

1. Appears dazed, stunned, or disoriented
2. Forgets plays or demonstrates short-term memory difficulties (e.g. is unsure of the game, score, or opponent)
3. Exhibits difficulties with balance or coordination
4. Answers questions slowly or inaccurately
5. Loses consciousness
6. Demonstrates behavior or personality changes
7. Is unable to recall events prior to or after the hit



**What can happen if my child/player keeps on playing with a concussion or returns too soon?**

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athletes' safety.

**If you think your child/player has suffered a concussion**

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear. Close observation of the athlete should continue for several hours.

An athlete who is suspected of sustaining a concussion or head injury in a practice or game shall be removed from competition at that time and may not return to play until the athlete receives written clearance from a physician trained in the evaluation and management of concussions that states the student athlete is asymptomatic at rest and may begin the graduated return to play protocol. The graduated return to play protocol is a series of six steps, the first being a completion of a full day of normal cognitive activities without re-emergence of symptoms.

Day 2: light aerobic exercise, keeping the student's heart rate <70% max

Day 3: sport specific exercises: running, etc. No head impact activities.

Day 4: non-contact training drills such as passing, blocking, etc. No resistance training.

Day 5: normal training/practice activities, following medical clearance.

Day 6: return to play involving normal game exertion or game activity.

You should also inform your child's Coach, Athletic Trainer (ATC), and/or Athletic Director, if you think that your child/player may have a concussion. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:

<http://www.cdc.gov/ConcussionInYouthSports>

<http://www.nfhslearn.com>



**NJSIAA STEROID TESTING POLICY**  
**CONSENT TO RANDOM TESTING**

By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that, if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Print Student-Athlete's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Print Parent/Guardian's Name

\_\_\_\_\_  
Date

**NJSIAA PARENT/GUARDIAN**  
**CONCUSSION POLICY ACKNOWLEDGMENT FORM**

By signing below, we agree to abide by the NJSIAA Concussion Policy. We have read and understand the risks associated with continuing to play with the signs and symptoms of a concussion.

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Print Student-Athlete's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Print Parent/Guardian's Name

\_\_\_\_\_  
Date

State of New Jersey  
DEPARTMENT OF EDUCATION

**Sudden Cardiac Death Pamphlet  
Sign-Off Sheet**

Name of School District: \_\_\_\_\_

Name of Local School: \_\_\_\_\_

I/We acknowledge that we received and reviewed the Sudden Cardiac Death in Young Athletes pamphlet.

Student Signature: \_\_\_\_\_

Parent or Guardian  
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Website Resources

- Sudden Death in Athletes at [www.suddendeathathletes.org](http://www.suddendeathathletes.org)
- Hypertrophic Cardiomyopathy Association [www.shim.org](http://www.shim.org)
- American Heart Association [www.heart.org](http://www.heart.org)

## Collaborating Agencies:

American Academy of Pediatrics  
New Jersey Chapter  
3636 Quakerbridge Road, Suite 108  
Hamilton, NJ 08618  
(p) 609-442-0014  
(f) 609-442-0016  
[www.aap.org](http://www.aap.org)

American Heart Association  
1 Union Street, Suite 301  
Robbinsville, NJ 08691  
(p) 609-208-0020  
[www.heart.org](http://www.heart.org)

New Jersey Department of Education  
PO Box 600  
Trenton, NJ 08646-0800  
(p) 609-282-4489  
[www.state.nj.us/education](http://www.state.nj.us/education)

New Jersey Department of Health  
and Senior Services  
P.O. Box 380  
Trenton, NJ 08646-0380  
(p) 609-292-7657  
[www.state.nj.us/health](http://www.state.nj.us/health)

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Final editor: Stephen A. Rice, MD, PhD - January 2011



# Sudden Cardiac Death in Young Athletes



**The Basic Facts on Sudden Cardiac Death in Young Athletes**

**American Academy of Pediatrics**

**New Jersey Chapter**

**DEDICATED TO THE HEALTH OF ALL CHILDREN**

**American Heart Association**

**Learn and Live**

## SUDDEN CARDIAC DEATH IN YOUNG ATHLETES

**S**udden death in young athletes between the ages of 10 and 19 is very rare. What, if anything, can be done to prevent this kind of tragedy?

What is sudden cardiac death in the young athletes?

Sudden cardiac death is the result of an unexpected failure of proper heart function, usually (about 60% of the time) during or immediately after exercise without trauma. Since the heart stops pumping adequately, the athlete quickly collapses, loses consciousness, and ultimately dies unless normal heart rhythm is restored using an automated external defibrillator (AED).

How common is sudden death in young athletes?

Sudden cardiac death in young athletes is very rare. About 100 such deaths are reported in the United States per year. The chance of sudden death occurring to any individual high school athlete is about one in 200,000 per year.

Sudden cardiac death is more common: in males than in females; in football and basketball than in other sports; and in African-Americans than in other races and ethnic groups.

What are the most common causes?

Research suggests that the main cause is a loss of proper heart rhythm, causing the heart to quiver instead of pumping

blood to the brain and body. This is called *ventricular fibrillation* (ver-TREEK-you-lar fib-roo-LAY-shun). The problem is usually caused by one of several cardiovascular abnormalities and electrical diseases of the heart that go unnoticed in healthy-appearing athletes.

The most common cause of sudden death in an athlete is *hypertrophic cardiomyopathy* (ih-pee-TRO-fo CAR-dee-oh-my-OP-a-thee) also called HCM. HCM is a disease of the heart with abnormal thickening of the heart muscle, which can cause serious heart rhythm problems and blockages to blood flow. This genetic disease runs in families and usually develops gradually over many years.

The second most likely cause is *congenital* (con-JEN-ih-el) (i.e., present from birth), *abnormalities of the coronary arteries*. This means that these blood vessels are connected to the main blood vessel of the heart in an abnormal way. This differs from blockages that may occur when people get older (commonly called "coronary artery disease," which may lead to a heart attack).

Other diseases of the heart that can lead to sudden death in young people include:

- *Myocarditis* (my-oh-car-DIE-tis), a acute inflammation of the heart muscle (usually due to a virus).

- Dilated cardiomyopathy, an enlargement of the heart for unknown reasons.

- Long QT syndrome and other electrical abnormalities of the heart which cause abnormal fast heart rhythms that can also run in families.



- Marfan syndrome, an inherited disorder that affects heart valves, walls of major arteries, eyes and the skeleton. It is generally seen in unusually tall athletes, especially if bending tail is not common in other family members.

### Are there warning signs to watch for?

In more than a third of these sudden cardiac deaths, there were warning signs that were not reported or taken seriously. Warning signs are:

- Fainting, a seizure or convulsions during physical activity
- Fainting or a seizure from emotional excitement, emotional distress or being startled
- Dizziness or lightheadedness, especially during exertion
- Chest pains, at rest or during exertion

- Palpitations - awareness of the heart beating unusually (skipping, irregular or extra beats) during athletics or during cool down periods after athletic participation
- Fatigue or tiring more quickly than peers
- Being unable to keep up with friends due to shortness of breath

### What are the current recommendations for screening young athletes?

New Jersey requires all school athletes to be examined by their primary care physician ("medical home") or school physician at least once per year. The New Jersey Department of Education requires use of the specific Annual Athletic Pre-Participation Physical Examination Form.

This process begins with the parents and student-athletes answering questions about symptoms during exercise (such as chest pain, dizziness, fainting, palpitations or shortness of breath); and questions about family health history.

The primary healthcare provider needs to know if any family member died suddenly during physical activity or during a seizure. They also need to know if anyone in the family under the age of 50 had an unexplained sudden death such as drowning or car accidents. This information must be provided annually for

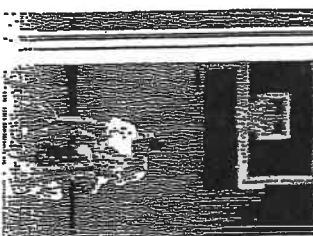


each exam because it is essential to identify those at risk for sudden cardiac death.

The required physical exam includes measurement of blood pressure and a careful listening examination of the heart, especially for murmurs and rhythm abnormalities. If there are no warning signs reported on the health history and no abnormalities discovered on exam, no further evaluation or testing is recommended.

### When should a student athlete see a heart specialist?

If the primary healthcare provider or school physician has concerns, a referral to a child heart specialist (pediatric cardiologist) is recommended. This specialist will perform a more thorough evaluation, including an electrocardiogram (ECG), which is a graph of the electrical activity of the heart. An echocardiogram, which is an ultrasound, is also used to allow for direct visualization of the heart structure, will likely also be done. The specialist may also order a treadmill exercise test and a monitor to enable a longer recording of the heart rhythm. None of the testing is invasive or uncomfortable.



Can sudden cardiac death be prevented just through proper screening?

A proper evaluation should find most, but not all, conditions that would cause sudden death in the athlete. This is because some diseases are difficult to uncover and may only develop later in life. Others can develop following a normal screening evaluation, such as an infection of the heart muscle from a virus.

This is why screening evaluations and a review of the family health history need to be performed on a yearly basis by the athlete's primary healthcare provider. With proper screening and evaluation, most cases can be identified and prevented.

### Why have an AED on site during sporting events?

The only effective treatment for ventricular fibrillation is immediate use of an automated external defibrillator (AED). An AED can restore the heart back into a normal rhythm. An AED is also life-saving for ventricular fibrillation caused by a blow to the chest over the heart (commotio cordis).

The American Academy of Pediatrics/New Jersey Chapter recommends that schools:

- Have an AED available at every sports event (three minutes total time to reach and return with the AED)
- Have personnel available who are trained in AED use present at practices and games.
- Have coaches and athletic trainers trained in basic life support techniques (CPR)
- Call 911 immediately while someone is retrieving the AED.

## Think you know how to wash your hands?

A little splash of water is NOT enough to clean your hands. Good handwashing requires soap, water, and friction.

Follow these easy steps to be sure your hands are getting clean each time you wash:

- Use warm water and soap
- Rub hands vigorously for 20 seconds
- Wash palms, backs, under nails, between fingers, and wrists
- Rinse off all soap
- Dry hands with a paper towel
- Use the paper towel to turn off the water tap
- Use the paper towel to open the bathroom door
- Discard the paper towel immediately after leaving the bathroom

**Wash your hands frequently!!!**

## What should you do if you think you have a MRSA skin infection?

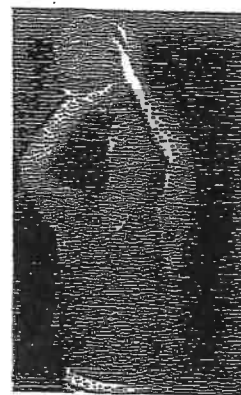
- Keep the skin sore covered with a bandage or clothing at all times.
- Do not share clothing, towels, or personal care items.
- Tell your school nurse immediately and seek medical care right away to prevent dangerous complications from developing.

**If you are diagnosed with a MRSA skin infection and see more than one health care provider, please let each health care provider know about your MRSA infection!!!**

NJ Department of Health & Senior Services  
Communicable Disease Service  
PO Box 369  
Trenton, NJ 08625-0369  
609-582-7500

For more information visit:  
<http://nj.gov/health/cd/mrsa/index.shtml>

# MRSA



**Preventing Skin Infections in School and Athletic Settings**



## What is MRSA?

Methicillin-resistant *Staphylococcus aureus* (MRSA) is a type of bacterium that is resistant to treatment with certain antibiotics. Most of the time, MRSA causes skin infections, but it can also lead to pneumonia and bloodstream infections. In the past, MRSA occurred in hospitals and nursing homes, but it is becoming more common in community settings such as schools and daycare centers.

People can become infected with MRSA by touching infected people, or contaminated objects/surfaces. These bacteria can then enter the body through cuts, scrapes, or other openings in the skin.

### What should students know about MRSA?

"Staph" bacteria can be found on the skin of healthy people, but only a

very small percentage is MRSA.

- Anyone can get MRSA.
- MRSA can spread easily among people who spend time in close contact with each other, such as household members and participants in close-contact sports (for example, football and wrestling).
- MRSA is NOT spread through the air.



### What are some of the high-risk behaviors associated with MRSA?

- Sharing personal care items such as razors, bar soap, cosmetics or towels
- Sharing clothing or uniforms that are not properly laundered
- Getting tattoos and body piercings using unsterile equipment
- Engaging in sexual activity or having close physical contact with MRSA-infected people
- Sharing syringes

- Sharing athletic gear (pads or helmets) that is not cleaned regularly.

### How can students protect themselves?

Personal hygiene is very important in preventing and controlling the spread of MRSA infections. Washing hands frequently throughout the day, showering after playing contact sports or using gym equipment, and laundering clothing in hot water will help prevent the spread of MRSA skin infections.

It is also a good idea to wipe down gym/sports equipment and exercise mats before and after use. Also, keep skin covered with clothing as an additional barrier. If you have a skin wound, be sure to cover it with a bandage.