NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION
SPORT PREPARTICIPATION EXAMINATION FORM

Patient's Name: _____ **Age:** _____ **Sex:** _____

This is a screening examination for participation in sports. This does not substitute for a comprehensive examination with your child's regular physician where important preventive health information can be covered.

Student-Athlete's Directions: Please review all questions with your parent or legal custodian and answer them to the best of your knowledge.
Parent's Directions: Please assure that all questions are answered to the best of your knowledge. If you do not understand or don't know the answer to a question please ask your doctor. Not disclosing accurate information may put your child at risk during sports activity.
Physician's Directions: We recommend carefully reviewing these questions and clarifying any "Yes" or "Unsure" answers.

Explain "Yes" or "Unsure" answers in the space provided below or on an attached separate sheet if needed.	Yes	No	Unsure
1. Does the student-athlete have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, etc.]? List:			
2. Is the student-athlete presently taking any medications or pills?			
3. Does the student-athlete have any allergies (medicine, bees or other stinging insects, latex)?			
4. Does the student-athlete have the sickle cell trait?			
5. Has the student-athlete ever had a head injury, been knocked out, or had a concussion?			
6. Has the student-athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?			
7. Has the student-athlete ever passed out or nearly passed out DURING exercise, emotion or startle?			
8. Has the student-athlete ever fainted or passed out AFTER exercise?			
9. Has the student-athlete had extreme fatigue (been really tired) with exercise (different from other children)?			
10. Has the student-athlete ever had trouble breathing during exercise, or a cough with exercise?			
11. Has the student-athlete ever been diagnosed with exercise-induced asthma?			
12. Has a doctor ever told the student-athlete that they have high blood pressure?			
13. Has a doctor ever told the student-athlete that they have a heart infection?			
14. Has a doctor ever ordered an EKG or other test for the student-athlete's heart, or has the athlete ever been told they have a murmur?			
15. Has the student-athlete ever had discomfort, pain, or pressure in his chest during or after exercise or complained of their heart "racing" or "skipping beats"?			
16. Has the student-athlete ever had a seizure or been diagnosed with an unexplained seizure problem?			
17. Has the student-athlete ever had a stinger, burner or pinched nerve?			
18. Has the student-athlete ever had any problems with their eyes or vision?			
19. Place a check beside each body part that the student-athlete ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints? □ Head □ Shoulder □ Thigh □ Neck □ Elbow □ Knee □ Chest □ Hip □ Forearm □ Shin/calf □ Back □ Wrist □ Ankle □ Hand □ Foot Other _____			
20. Has the student-athlete ever had an eating disorder, or do you have any concerns about your eating habits or weight?			
21. Has the student-athlete ever been hospitalized or had surgery?			
22. Has the student-athlete had a medical problem or injury since their last evaluation?			
23. (Place a check beside each statement that applies to the student-athlete, elaborate in the space provided below). □ 1. Has the student-athlete had little interest or pleasure in doing things? □ 2. Has the student-athlete been feeling down, depressed, or hopeless for more than 2 weeks in a row? □ 3. Has the student-athlete been feeling bad about himself/herself that they are a failure, or let their family down? □ 4. Has the student-athlete had thoughts that he/she would be better off dead or hurting themselves?			
FAMILY HISTORY			
24. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?			
25. Has any family member had unexplained heart attacks, fainting or seizures?			
26. Does the athlete have a father, mother or brother with sickle cell disease?			

Explain "yes" or "unsure" answers here: _____

_____

By signing below I agree that I have reviewed and answered each question above. Every question is answered completely and is correct to the best of my knowledge. Furthermore, as parent or legal custodian, I give consent for this examination and give permission for my child to participate in sports.

Signature of parent/legal custodian: _____ Date: _____ Phone #: _____

Signature of Athlete: _____ Date: _____

The signature above signifies that I give my permission for the Montgomery County Schools designated medical provider to perform a sports physical for my child and do release all involved parties (Montgomery County Schools, FirstHealth of the Carolinas, and individual providers) of any medical liability.

(Rev. 3/2019) Approved for 2019-20 School Year

Student-Athlete's Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ BP _____ (_____% ile) / _____ (_____% ile) Pulse: _____

Vision: R 20/_____ L 20/_____ Corrected: Y N

Physical Examination (Must be Completed by a Licensed Physician, Nurse Practitioner or Physician Assistant)

These are required elements for all examinations			
	NORMAL	**ABNORMAL**	**ABNORMAL FINDINGS**
PULSES			
HEART			
LUNGS			
SKIN			
NECK/BACK			
SHOULDER			
KNEE			
ANKLE/FOOT			
Other Orthopedic Problems			

Optional Examination Elements – Should be done if history indicates

HEENT			
ABDOMINAL			
GENITALIA (MALES)			
HERNIA (MALES)			

Clearance:

□ **A. Cleared**

□ **B. Cleared after completing evaluation/rehabilitation for :**

□ ***** C. Medical Waiver Form must be attached (for the condition of: _____)**

□ **D. Not cleared for:□ Collision □ Contact**

□ Non-contact _____Strenuous _____Moderately strenuous _____Non-strenuous

Due to: _____

_____

_____

Additional Recommendations/Rehab Instructions: _____

_____

_____

Name of Physician/Extender: _____ (Please print)

Signature of Physician/Extender _____ MD DO PA NP
(Signature and circle of designated degree required)

Date of Examination: _____

Address: 129 NC Hwy 109 S
Mt. Gilead, NC 27306

Phone: 910-572-1979

Physician Office Stamp:

West Middle School Based Health Center
129 NC Hwy 109 S
Mount Gilead, NC 27306
910-572-1979

(*** The following are considered disqualifying until appropriate medical and parental releases are obtained: post-operative clearance, acute infections, obvious growth retardation, uncontrolled diabetes, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or Stage 2 hypertension, enlarged liver or spleen, a chronic musculoskeletal condition that limits ability for safe exercise/sport (i.e. Klippel-Feil anomaly, Sprengel's deformity), history of uncontrolled seizures, absence of/ or one kidney, eye, testicle or ovary, etc.)