# 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.]?<br>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?<br>□ Head □ Shoulder □ Thigh □ Neck □ Elbow □ Knee □ Chest □ Hip<br>□ 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).<br>□ 1. Has the student-athlete had little interest or pleasure in doing things?<br>□ 2. Has the student-athlete been feeling down, depressed, or hopeless for more than 2 weeks in a row?<br>□ 3. Has the student-athlete been feeling bad about himself/herself that they are a failure, or let their family down?<br>□ 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: 1834 S Alt. 220 Hwy**
**Biscoe, NC 27209**

**Phone: 910-428-9392**

**Physician Office Stamp:**

**East Middle School Based Health Center**
**1834 S Alt. 220 Hwy**
**Biscoe, NC 27209**

(*** 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.)