

NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION SPORT PREPARTICIPATION EXAMINATION FORM

Student Athlete'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/Legal Custodian Directions: Please assure that all questions are answered to the best of your knowledge. If you do not understand or are unsure about 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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the student-athlete presently taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the student-athlete have any allergies (medicine, bees or other stinging insects, latex)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the student-athlete have the sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the student-athlete ever had a head injury, been knocked out, or had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the student-athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the student-athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the student-athlete ever fainted or passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the student-athlete had extreme fatigue (been really tired) with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has the student-athlete ever had trouble breathing during exercise, or a cough with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the student-athlete ever been diagnosed with exercise-induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has a doctor ever told the student-athlete that they have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has a doctor ever told the student-athlete that they have a heart infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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 heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Has the student-athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Has the student-athlete ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Has the student-athlete ever had any problems with their eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Place a check beside each body part that the student-athlete has ever sprained/strained, dislocated, fractured, broken had repeated swelling in or had any other type of injury to any bones or joints? <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hip <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hand <input type="checkbox"/> Foot Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Has the student-athlete ever had an eating disorder, or are there concerns about his/her eating habits or weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Has the student-athlete ever been hospitalized or had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Has the student-athlete had a medical problem or injury since their last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. (Place a check beside each statement that applies to the student-athlete, elaborate in the space provided below). <input type="checkbox"/> 1. Has the student-athlete had little interest or pleasure in doing things? <input type="checkbox"/> 2. Has the student-athlete been feeling down, depressed, or hopeless for more than 2 weeks in a row? <input type="checkbox"/> 3. Has the student-athlete been feeling bad about himself/herself that they are a failure, or let their family down? <input type="checkbox"/> 4. Has the student-athlete had thoughts that he/she would be better off dead or hurting themselves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Has any family member had unexplained heart attacks, fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Does the athlete have a father, mother or brother with sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

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

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

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

Physical Examination (Below Must be Completed by 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)

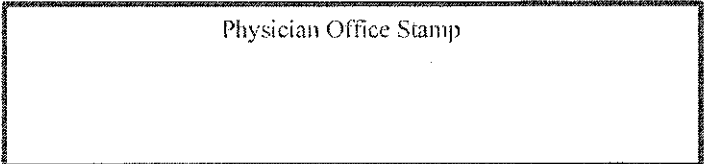
Signature of Physician/Extender: _____ MD DO PA NP (Please circle)

(Both signature and circle of designated degree required)

Date of Examination: _____

Address: _____

Phone: _____



(*** 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.)

This form is approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee and the NCHSAA Board of Directors.

Durham Public Schools
Assumption of Risk/Medical Treatment Release

Student Athlete's Name: _____ Date: _____
School: _____
Sport(s): _____

The Durham Public Schools system makes every effort to prevent injuries, but injuries do occur in athletics. By signing below, I (parent/guardian name) _____ do understand:

- 1. The rules and procedures of the sports listed above and am aware of the risks involved in playing them
2. The necessity of using the proper techniques and protective equipment (when needed).

I recognize that there are inherent risks in all athletic events (head and spinal cord injuries, fractures, internal injuries, etc.) and hereby give my permission for my son/daughter to participate in any and all interscholastic athletic events sponsored by Durham Public Schools.

Permission is hereby granted to Durham Public Schools and its authorized representatives to initiate treatment and rehabilitation of injuries and authorize any needed emergency major medical or minor surgical treatment, x-ray, examination, and immunization of the above named participant by appropriate medical personnel. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that every attempt will be made by the physician to contact me in the most expeditious manner possible. If said physician is unable to communicate with me, the treatment necessary for the best interest/safety of the above named individual may be rendered.

I hereby release the Durham Public Schools system, local/individual school personnel, and the individual members of each athletic department including but not limited to, its coaches, certified athletic trainers, first responders, student athletic trainers, athletic training student aides, administrators, attending physicians, and all other connected with school athletic activities, from any and all damages for injuries sustained by my son/daughter while participating in any sports activity associated with Durham Public Schools. I do, hereby, agree to hold harmless any and all the above from any and all damages which they may suffer as a result of injuries sustained by my son/daughter while participating as above stated.

Are you presently taking any medications, supplements, or pills? Yes _____ No _____
If yes, please list: _____

Does student named above have allergies? (medicine, beestings, hay fever, etc) Yes _____ No _____
If yes, please list: _____

Parent/Guardian Contact:
Name: _____
Phone #: Primary _____ Secondary: _____ Cell: _____
Address: _____ City: _____ Zip: _____

Emergency Contact: Name: _____
Phone #: Primary _____ Secondary: _____ Cell: _____

SIGNATURE:(Parent/Guardian): _____ Date: ____/____/____

Please Read the Following Form Carefully

**Authorization For Release of Protected Health Information For Athletic Participating
In Durham Public Schools Athletics Program**

Once properly signed, this authorization will allow for the release of protected health information to the Durham Public Schools Systems (DPS) by physicians and health care providers (Providers) rendering services to DPS athletes. The purpose of the release of the protected health information is to allow the DPS Athletic Program to determine the advisability of an athlete's participation in DPS athletics. An example would be the release of a screening physical examination.

By signing this Authorization for my son, daughter or other person for whom I have legal authority to act (hereinafter referred to as "Athlete"), I hereby authorize health care providers (including, but not limited to, the Duke University Sports Medicine Program and its physicians and providers) that are contracted with DPS to release to each other and to the DPS oral and written medical information relating to the Athlete's medical or physical condition, illness or injury that may have a bearing upon past, present, or future participation in athletics of DPS Athletic Program. The medical information should be used by the DPS Athletic Program for the purpose of determining the advisability of the Athlete's participation in DPS athletics.

This authorization is expressly bound by all the following conditions:

This Authorization will automatically expire upon the Athlete's termination of participation or ineligibility in DPS Athletics, except to the extent relied upon for disclosures made prior to the automatic expiration.

This Authorization may be revoked at any time, provided the revocation *is a properly executed written document and delivered to the Director of Athletics for Durham Public Schools*. As soon as practicable, DPS shall inform each contracted health care provider prior of each Athlete's revocation. However, any such revocation shall not affect disclosures made by a health care provider prior to that health care provider's receipt of the revocation for DPS. In addition, such revocation shall not affect disclosures made prior to the receipt of the revocation to the extent that this Authorization was relied upon for such affect disclosures made prior to the receipt of the revocation to the extent that this Authorization was relied upon for such disclosures.

This Authorization is not intended to alter the Athlete's ability to receive medical care from any health care provider regardless of whether this Authorization is agreed to or refused.

This Authorization shall cover actions by and for Duke University, Duke University Health System, Inc. and Private Diagnostic Clinic, PLLC, and all of their respective employees, workforce, and business associates, and all other physicians and health care providers contracted with DPS and their respective employees, workforce, and business associates. For a complete list of contracted health care providers for DPS that may release medical information pursuant to the Authorization, please contact Durham Public Schools.

The athlete and Parent/Guardian will receive a complete copy of the signed Authorization.

A copy of this Authorization and any revocation of it will be kept by both the Duke Sports Medicine Office, Durham Public Schools and other health care providers contracted with Durham Public Schools.

Protected health information released by the health care providers to Durham Public Schools is not protected by this Authorization from re-disclosure by Durham Public Schools.

Date: _____

Parent/Guardian Signature

Printed Name

Relationship to Athlete

Athlete's Name - Printed

Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Information Sheet

What is a concussion? A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

How do I know if I have a concussion? There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Headache	Irritability-things bother you more easily	Sleeping more than usual
Taking longer to figure things out	Fuzzy or blurry vision	Sadness	Sleeping less than usual
Difficulty concentrating	Feeling sick to your stomach/queasy	Being more moody	Trouble falling asleep
Difficulty remembering new information	Vomiting/throwing up	Feeling nervous or worried	Feeling tired
	Dizziness	Crying more	
	Balance problems		
	Sensitivity to noise or light		

Table is adapted from the Centers for Disease Control and Prevention (<http://www.cdc.gov/concussion/>)

What should I do if I think I have a concussion? If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

When should I be particularly concerned? If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

What are some of the problems that may affect me after a concussion? You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur. Once you have a concussion, you are more likely to have another concussion.

How do I know when it's ok to return to physical activity and my sport after a concussion? After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign your brain has not recovered from the injury.

This information is provided to you by the UNC Matthew Gfeller Sport-Related TBI Research Center, North Carolina Medical Society, North Carolina Athletic Trainers' Association, Brain Injury Association of North Carolina, North Carolina Neuropsychological Society, and North Carolina High School Athletic Association.

Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Statement Form

Instructions: The student athlete and his/her parent or legal custodian, must initial beside each statement acknowledging that they have read and understand the corresponding statement. The student-athlete should initial in the left column and the parent or legal custodian should initial in the right column. Some statements are applicable only to the student-athlete and should only be initialed by the student-athlete. This form must be completed for each student-athlete, even if there are multiple student-athletes in the household.

Student-Athlete Name: (please print) _____

Parent/Legal Custodian Name(s): (please print) _____

Student-Athlete Initials		Parent/Legal Custodian(s) Initials
	A concussion is a brain injury, which should be reported to my parent(s) or legal custodian(s), my or my child's coach(es), or a medical professional if one is available.	
	A concussion cannot be "seen." Some signs and symptoms might be present immediately; however, other symptoms can appear hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	Not Applicable
	If I think a teammate has a concussion, I should tell my coach(es), parent(s)/ legal custodian(s) or medical professional about the concussion.	Not Applicable
	I, or my child, will not return to play in a game or practice if a hit to my, or my child's, head or body causes any concussion-related symptoms.	
	I, or my child, will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away, right away. I realize that resolution from a concussion is a process that may require more than one medical visit.	
	I realize that ER/Urgent Care physicians will not provide clearance to return to play or practice, if seen immediately or shortly after the injury.	
	After a concussion, the brain needs time to heal. I understand that I or my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms listed on the Student-Athlete/ Parent Legal Custodian Concussion Information Sheet.	
	I have asked an adult and/or medical professional to explain any information contained in the Student-Athlete & Parent Concussion Statement Form or Information Sheet that I do not understand.	

By signing below, we agree that we have read and understand the information contained in the Student-Athlete & Parent/Legal Custodian Concussion Statement Form, and have initialed appropriately beside each statement.

Signature of Student-Athlete

Date

Signature of Parent/Legal Custodian

Date

Durham Public Schools Student Athlete Address Documentation Form

This is to certify that _____ parent/guardian of _____ an athlete in Durham Public Schools do certify that my primary residence is located in the attendance zone of Riverside High School. This is my primary domicile, and I realize that for athletic purposes I can only have one primary domicile.

I further understand that this residence must be inside of the Durham Public Schools Administrative Unit.

I certify that my address is within the said district, and that the school in which my child attends is in the attendance zone for the school that he/she is currently attending.

If I am not attending the school that is my normal attendance zone assignment, I am attending this school because the Office of Student Assignment has issued an approved student transfer or an approved program assignment for me to attend my current school valid for the current school year. If the student is assigned to Riverside through a pathway check the appropriate box below.

I also realize that if I have given an incorrect or false address that my child will be declared ineligible to participate in the school sports program.

My signature further signifies that I have completed this form and that I fully understand the consequences associated with giving information that is incorrect and false.

Please check the appropriate box if your son/daughter is enrolled in either of the following programs:

- Engineering
 ROTC

Student and Legal Guardian's Address:

Street address

City

State

Zip Code

Parent/Guardian Signature: _____

Date: _____

Student Signature: _____

Date: _____

2019-20 North Carolina High School Athletic Association Eligibility and Authorization Statement

This document is to be signed by the participant of an NCHSAA member school and by the participant's parent.

I have read, understand and acknowledge receipt of the eligibility rules of the North Carolina High School Athletic Association. I understand that a copy of the *NCHSAA Handbook* is on file with the principal and athletic administrator and that I may review it, in its entirety, if I so choose. All NCHSAA bylaws and regulations from the *Handbook* are also posted on the NCHSAA web site at www.nchsaa.org

I understand that an NCHSAA member school must **adhere to all rules and regulations** that pertain to the interscholastic athletics programs that the school sponsors, but that local rules may be more stringent than NCHSAA rules.

I understand that participation in interscholastic athletics is a **privilege not a right**.

Student Code of Responsibility

As a student athlete, I **understand and accept** the following responsibilities:

I will **respect the rights and beliefs** of others and will treat others with courtesy and consideration.

I will be **fully responsible** for my own actions and the consequences of my actions.

I will **respect the property** of others.

I will **respect and obey the rules** of my school and laws of my community, state and country.

I will **show respect to those who are responsible for enforcing the rules** of my school and the laws of my community, state and country.

I **understand that a student whose character or conduct violates** the school's Athletic Code or School Code of Responsibility could be deemed ineligible for a period of time as determined by the principal or school system Administration

I understand that if I drop a class, take course work through Post Secondary Enrollment Option, or other educational options, this action could affect compliance with NCHSAA academic standards and my eligibility.

Informed Consent – By its nature, participation in interscholastic athletics includes risk of injury and transmission of infectious disease such as HIV and Hepatitis B. Although serious injuries are not common and the risk of HIV transmission is almost nonexistent in supervised school athletic programs, it is impossible to eliminate all risk. Participants have a responsibility to help reduce that risk. Participants must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily. **PARENTS, LEGAL CUSTODIAN'S OR STUDENTS WHO MAY NOT WISH TO ACCEPT RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM. STUDENTS MAY NOT PARTICIPATE IN AN NCHSAA-SPONSORED SPORT WITHOUT THE STUDENT'S AND PARENT'S/GUARDIAN'S SIGNATURE.**

I understand that in the case of **injury or illness requiring treatment by medical personnel and transportation to a health care facility**, that a reasonable attempt will be made to contact the parent/legal custodian in the case of the student-athlete being a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital.

I consent to medical treatment for the student following an injury or illness suffered during practice and/or a contest.

I understand all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further I understand that if my student is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation that day. After that day, written authorization from a physician (M.D. or D.O.) or an athletic trainer working under the supervision of a physician will be required in order for the student to return to participation.

I have received, read and signed the Gfeller-Waller Concussion Information Sheet.

I consent to the NCHSAA use of the herein named student's name, likeness, and athletic-related information in reports of contests, promotional literature of the Association and other materials and releases related to interscholastic athletics.

By signing this document, we acknowledge that we have read the above information and that we consent to the herein named student's participation.

Must Be Signed Before Participation

Student's Signature

Birth date

Grade in School

Date

Signature of Parent or Legal Custodian

Date