

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: _____

| |
|------------------------|
| Physician Office Stamp |
|------------------------|

(*** 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.