

NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION SPORT PREPARTICIPATION EXAMINATION FORM

Patient's Name: _____

Age: _____

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.

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. 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 positive answers.

Explain "Yes" answers below	Yes	No	Don't know
1. Has the athlete ever been hospitalized or had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the athlete presently taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the athlete have any allergies (medicine, bees or other stinging insects, latex)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the athlete ever fainted or passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the athlete had extreme fatigue associated with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the athlete ever had trouble breathing during exercise, or a cough with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the athlete ever been diagnosed with exercise-induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has a doctor ever told the athlete that they have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has a doctor ever told the athlete that they have a heart infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has a doctor ever ordered an EKG or other test for the athlete's heart, or has the athlete ever been told they have a murmur?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the 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"/>
13. Has the athlete ever had a head injury, been knocked out, or had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Has the athlete ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Has the athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Has the athlete ever had any problems with their eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Has the athlete ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<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			
19. Has the athlete ever had an eating disorder, or do you have any concerns about your eating habits or weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Does the athlete have any chronic medical illnesses (diabetes, asthma, kidney problems, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Has the athlete had a medical problem or injury since their last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Does the athlete have the sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FAMILY HISTORY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. 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"/>
24. Has any family member had unexplained heart attacks, fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Does the athlete have a father, mother or brother with sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Elaborate on any positive (yes) answers: _____

I have reviewed and answered each question above, and assure that all are accurate responses. Furthermore, I give permission for my child to participate in sports.

Signature of parent/legal custodian: _____ Date: _____

Signature of Athlete: _____ Date: _____ Phone #: _____

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

Athlete's Name _____ Age _____ Date of Birth _____

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

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

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. Not cleared for: Collision Contact
 Non-contact _____ Strenuous _____ Moderately strenuous _____ Non-strenuous

Due to: _____

Additional Recommendations/Rehab Instructions: _____

Name of Physician/Extender: _____

Signature of Physician/Extender _____ MD DO PA NP

(Signature and circle of designated degree required)

Date of exam: _____

Address: _____

Phone _____

<p>Physician Office Stamp:</p>

(** The following are considered disqualifying until appropriate medical and parental releases are obtained: post-operative clearance, acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or 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 convulsions or concussions, absence of/ or one kidney, eye, testicle or ovary, etc.)

This form approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee December 2009, and the NCHSAA Board of Directors reviewed annually.