

# 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.***

**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 positive or Don't Know answers.

| Explain "Yes" answers below  | Yes                      | No                       | Don't know               |
|--|--------------------------|--------------------------|--------------------------|
| 1. Does the athlete have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, etc.]?<br>List: _____   | <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. Does the athlete have the sickle cell trait?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has the 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 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 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 athlete ever fainted or passed out AFTER exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has the 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 athlete ever had trouble breathing during exercise, or a cough with exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has the athlete ever been diagnosed with exercise-induced asthma ?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has a doctor ever told the athlete that they have high blood pressure?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has a doctor ever told the 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 athlete's heart, or has the athlete ever been told they have a murmur?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. 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"/> |
| 16. Has the 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 athlete ever had a stinger, burner or pinched nerve?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Has the athlete ever had any problems with their eyes or vision?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Has the athlete ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints?<br><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<br><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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. 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"/> |
| 21. Has the athlete ever been hospitalized or had surgery?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Has the athlete had a medical problem or injury since their last evaluation?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>FAMILY HISTORY</b>  | <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: \_\_\_\_\_

***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: \_\_\_\_\_

Signature of Athlete: \_\_\_\_\_ Date: \_\_\_\_\_ Phone #: \_\_\_\_\_

***Physical Examination (Must be Completed by a Licensed Physician, Nurse Practitioner or Physician 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. 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: \_\_\_\_\_

Signature of Physician/Extender \_\_\_\_\_ MD DO PA NP

(Signature and circle of designated degree required)

Date of exam: \_\_\_\_\_

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.)