Print Form

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?	❑	❑	❑
2. Is the athlete presently taking any medications or pills?	❑	❑	❑
3. Does the athlete have any allergies (medicine, bees or other stinging insects, latex)?	❑	❑	❑
4. Has the athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	❑	❑	❑
5. Has the athlete ever fainted or passed out AFTER exercise?	❑	❑	❑
6. Has the athlete had extreme fatigue associated with exercise (different from other children)?	❑	❑	❑
7. Has the athlete ever had trouble breathing during exercise, or a cough with exercise?	❑	❑	❑
8. Has the athlete ever been diagnosed with exercise-induced asthma?	❑	❑	❑
9. Has a doctor ever told the athlete that they have high blood pressure?	❑	❑	❑
10. Has a doctor ever told the athlete that they have a heart infection?	❑	❑	❑
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?	❑	❑	❑
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"?	❑	❑	❑
13. Has the athlete ever had a head injury, been knocked out, or had a concussion?	❑	❑	❑
14. Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	❑	❑	❑
15. Has the athlete ever had a stinger, burner or pinched nerve?	❑	❑	❑
16. Has the athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	❑	❑	❑
17. Has the athlete ever had any problems with their eyes or vision?	❑	❑	❑
18. Has the athlete ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints?	❑	❑	❑
❑ Head ❑ Shoulder ❑ Thigh ❑ Neck ❑ Elbow ❑ Knee ❑ Chest ❑Hip ❑ Forearm ❑ Shin/calf ❑ Back ❑ Wrist ❑ Ankle ❑ Hand ❑ Foot			
19. Has the athlete ever had an eating disorder, or do you have any concerns about your eating habits or weight?	❑	❑	❑
20. Does the athlete have any chronic medical illnesses (diabetes, asthma, kidney problems, etc.)?	❑	❑	❑
21. Has the athlete had a medical problem or injury since their last evaluation?	❑	❑	❑
22. Does the athlete have the sickle cell trait?	❑	❑	❑
FAMILY HISTORY	❑	❑	❑
23. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?	❑	❑	❑
24. Has any family member had unexplained heart attacks, fainting or seizures?	❑	❑	❑
25. Does the athlete have a father, mother or brother with sickle cell disease?	❑	❑	❑

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 #: _____

This form approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee October 2009, reviewed annually.

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_____

Physician Office Stamp:

(** 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.)

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