

ATHLETIC PARTICIPATION/PERMISSION FORM

This form is to be filled out completely by parent and physician before the student can participate in the school athletic programs.

PRESENT DATE: _____

STUDENT'S NAME: _____ Male _____ Female _____

SCHOOL: _____ GRADE: _____

ADDRESS OF STUDENT: _____

HOME PHONE #: _____ DATE OF BIRTH: _____

PARENT'S NAME: _____ Parent's Work Phone: (Mother)# _____
(Father)# _____

I hereby apply for permission to participate in the following interscholastic sport(s): _____

I certify that the information in this application is correct, and I agree to abide by the eligibility rules and regulations governing athletics as set forth by the North Carolina State Board of Education and Association to which my school is a member.

Signature of Student _____

MEDICAL HISTORY *(to be completed by Parents)*

STUDENT NAME: _____ AGE: _____ DATE: _____

Is there any known history of:

If "Yes" Explain:

- | | | |
|---|--------------------|-------|
| A. Birth deformities (one eye, one kidney, etc.). | Yes _____ No _____ | _____ |
| B. Past illness of more than one week's duration? | Yes _____ No _____ | _____ |
| C. Medical conditions currently under treatment? | Yes _____ No _____ | _____ |
| D. Fractures or other disabling injuries? | Yes _____ No _____ | _____ |
| E. Any permanent deformity or disability? | Yes _____ No _____ | _____ |
| F. Allergy (drugs, food, clothing, etc.)? | Yes _____ No _____ | _____ |
| G. Mental disorder or convulsions? | Yes _____ No _____ | _____ |

If you need more room to explain any above questions answered "Yes." _____

PARENTAL PERMISSION *(to be completed by Parents)*

As parent or legal guardian of _____, I hereby give my consent for his/her practice and play in the athletic events listed above.

I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment.

I agree to the need for a screening medical examination and certify that the medical history is accurate to the best of my knowledge.

If your child/student should need emergency care immediately please indicate which physician and hospital you wish for us to transport him/her to. We will also need the following Insurance and Emergency information:

Is your son/daughter presently covered by a Hospital Insurance policy? Yes _____ No _____

(You will be required to purchase insurance for your child if your answer is "NO" to the question above.)

Health Insurance Company Name: _____

Insurance Policy # _____

Indicate Hospital Preference: _____

Physician's Name & Office Phone # _____

Signature of Parent or Legal Guardian: _____ Date _____

Parent's Emergency Phone #'s: _____

[Other person(s) you would like us to contact: _____ # _____

in the event you cannot be reached]: _____ # _____

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.)