

# Emergency Contact Form - East Mecklenburg High School

Student Athlete: \_\_\_\_\_  
(Last) (First) (Nickname)

Student Social Security: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_  
(Street Address) (Zip Code)

Mother's Name: \_\_\_\_\_  
(First) (Last)

Mother's Phone Numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Place of Work \_\_\_\_\_

Father's Name: \_\_\_\_\_  
(First) (Last)

Father's Phone Numbers: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Place of Work \_\_\_\_\_

Another Emergency Contact Person: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Place of Work \_\_\_\_\_

Personal Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Allergic to Medication: (list) \_\_\_\_\_

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## Parental Permission

As parent or legal guardian of \_\_\_\_\_, I hereby give my consent for his/her participation with the activities associated with the East Mecklenburg High School \_\_\_\_\_ team.

I also grant permission for treatment deemed necessary for any condition arising during this participation, 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 information that I provided is accurate to the best of my knowledge.

Signature of Parent of Legal Guardian \_\_\_\_\_



**Charlotte-Mecklenburg Schools  
High School Student-Athlete Pre-Participation Form**

***\* Please take the time, read through the questions, and answer to the best of your knowledge.\****

**PERSONAL & EMERGENCY CONTACT INFORMATION**

Name (First, MI, Last): \_\_\_\_\_ CMS Student ID # \_\_\_\_\_  
 Gender:  M  F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Parent(s) / Legal Guardian(s) Residing With: \_\_\_\_\_ Who has legal custody? \_\_\_\_\_  
 Father's Name: \_\_\_\_\_ Alternate Phone (Work or Cellular): \_\_\_\_\_  
 Mother's Name: \_\_\_\_\_ Alternate Phone (Work or Cellular): \_\_\_\_\_  
 Street Address: \_\_\_\_\_ Apartment / Unit # \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Family Physician/Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Preferred Hospital: \_\_\_\_\_ Permission to Transport:  Yes  No

**SPORT (\*check all sports you are considering to participate in\*)**

FALL	WINTER	SPRING
<input type="checkbox"/> Football	<input type="checkbox"/> Men Basketball	<input type="checkbox"/> Baseball
<input type="checkbox"/> Men Cross-Country	<input type="checkbox"/> Women Basketball	<input type="checkbox"/> Softball
<input type="checkbox"/> Men Soccer	<input type="checkbox"/> Wrestling	<input type="checkbox"/> Men Track
<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Women Track
<input type="checkbox"/> Women Tennis	<input type="checkbox"/> Men Swimming / Diving	<input type="checkbox"/> Women Soccer
<input type="checkbox"/> Women Cross-Country	<input type="checkbox"/> Women Swimming / Diving	<input type="checkbox"/> Men Golf
<input type="checkbox"/> Women Volleyball	<input type="checkbox"/> Men's Indoor Track	<input type="checkbox"/> Men Tennis
<input type="checkbox"/> Women Golf	<input type="checkbox"/> Women's Indoor Track	<input type="checkbox"/> Men Lacrosse
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Women Lacrosse

**INSURANCE**

School Board Policy (#5143) requires that all students who participate in athletics be adequately covered by medical or accident insurance. We acknowledge that it is the signed responsibility to notify CMS of any changes that occur to the personal insurance policy below and affect the procedures in which the above-named individual may receive treatment; this includes loss of coverage. We certify that we have purchased and will maintain in full force and effect during student-athlete's participation in athletics the following insurance policy:  
 Check One:  School Accident Insurance  Personal Insurance Company

Name of Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Insurance Phone for Authorization \_\_\_\_\_ Policy Holder \_\_\_\_\_

**RELEASE**

In consideration of CMS allowing the above-named individual to participate in athletics, we agree to release and hold CMS, its athletic coaches, and other employees free, harmless and indemnified from and against any and all claims, suits, or causes of action arising from or out of injury that the student-athlete may suffer from participation in athletics other than an injury from gross or willful negligence.

**ASSUMPTION OF RISK**

We acknowledge and understand that there is a risk of injury involved in athletic participation. We understand that the student-athlete will be under the supervision and the instructions of the coach in order to reduce the risk of injury to the student and other athletes. However, we acknowledge and understand that neither the coach nor CMS can eliminate the risk of injury in sports. Injuries may and do occur. Sports injuries can be severe and in some cases may result in permanent disability or even death. We freely, knowingly, and willfully accept and assume the risk of injury that might occur from participation in athletics.

**HIPAA / FERPA RELEASE**

The above named student-athlete has opted his/her rights under the US Department of Health and Human Resources guidelines. By signing this release, the student-athlete allows sharing of medical information between the Sports Medicine Staff (team physicians and medical staff, athletic trainers, and student assistants), the CMS Athletics Staff (Athletic Director and Coaches), CMS Administration and his/her medical provider(s). In the event of an emergency situation, information may be shared with emergency medical personnel. Every reasonable effort will be made to protect this information. It is understood that once this medical information is disclosed, it is no longer protected under the HIPAA/FERPA guidelines.

**PARENT / GUARDIAN SIGNATURE**

Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# 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"/>
<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: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

***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><b>Physician Office Stamp:</b></p>
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(\*\* 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.)

IMPORTANT: THIS NOTICE AND RELEASE MUST BE SIGNED AND RETURNED BEFORE YOUR SON/DAUGHTER CAN PARTICIPATE IN THIS PROGRAM.

TO: Parents of Students Interested in Participating in Athletics

SUBJECT: STUDENT INSURANCE FOR ATHLETICS

SPORT(S) \_\_\_\_\_

Please read this Notice and Release and make sure you understand its provisions before deciding whether to permit your son or daughter to participate in middle or senior high school athletics.

1. Board of Education Policy No. 5143 requires that the Student Accident Insurance offered by the school system will be required for all students participating in middle and senior high school athletics unless and insurance waiver form is signed by the parent indicating adequate personal insurance and releasing the Board of Education and its employees from responsibility for any claim due to injuries received while participating in a school sponsored athletic program.
2. There ARE limitations in the Student Accident Insurance coverage. IT WILL NOT ALWAYS PAY ALL OF THE CHARGES INCURRED FOR EVERY ACCIDENT. For a summary of the coverage and benefits provided by the Student Accident Insurance, please read the current Student Accident Brochure carefully that has been furnished to each student at the beginning of the school year. If you did not receive the brochure or if you have questions about the insurance coverage provided under this policy, contact the Athletic Director at the school where your child is enrolled.
3. To be eligible to practice or participate in any school athletic program, each participant must receive an ANNUAL MEDICAL EXAMINATION and return a physical examination form each calendar year (once every 365 days) signed by a physician licensed to practice medicine.
4. Neither the Board of Education nor any of its employees will assume responsibility for claims resulting from injury to your child while he or she is participating in the school athletic program. This means that you will have to pay for any medical expenses not covered by the Student Accident Insurance, any personal insurance coverage that you might have and/or any other applicable insurance.

I, \_\_\_\_\_, (print name) state that I have read and understand the provisions of the Notice and Release and the Student Accident Brochure. I further state that prior to signing this document, I have had an opportunity to ask questions and that my questions have been answered to my satisfaction. I acknowledge that neither the Board nor any of its employees assumes any responsibility for claims resulting from injury to my child while he or she is participating in the school athletic program. In consideration of my child being permitted to participate in this school athletic program, I HEREBY WAIVE, RELEASE AND DISCHARGE the Charlotte-Mecklenburg Board of Education and its employees from any responsibility for claims resulting from injuries to my child due to his or her participation in this school athletic program. I hereby certify that my child has received a MEDICAL EXAMINATION and has returned a physical examination form in compliance with the policy set forth in paragraph 3 of the Notice and Release. Based upon this foregoing, I certify that I consent to have my child participate in the school athletic activity or activities identified above. With regard to insurance coverage for my child's participation in athletics, I make the following representation and selection (check one, sign and return promptly):

\_\_\_\_\_ I have adequate personal insurance that will cover injuries that might be sustained by my child as a result of his/her participation in school athletics. I understand that in the event that my child sustains any injuries as a result of his/her participation in school athletics, I am responsible for payment of medical expenses or other items not covered by any personal insurance.

\_\_\_\_\_ My son/daughter has enrolled in the Student Accident Insurance Program on \_\_\_\_/\_\_\_\_/\_\_\_\_ and I understand that in the event my child sustains any injuries as a result of his/her participation in school athletics, I am responsible for the payment of any medical expenses or other items not covered by the Student Accident Insurance.

SIGNED: (Parent or Legal Guardian) \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS: \_\_\_\_\_

STUDENT'S FULL NAME: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ STUDENT'S SS# \_\_\_\_\_