ATHLETIC PARTICIPATION/PERMISSION FORM

This form is to be filled-out completely by Parent & 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):_____

(EXAMPLE: Baseball, Tennis, XC, etc.)

_____

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

Signature of Student_____

MEDICAL HISTORY - *(to be completed by Parents)*

STUDENT NAME: _____ **AGE:** _____ **Today's 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 & play in the athletic events/sports 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 & 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:** _____ **Sex:** _____

This is a screening examination for participation in sports. <u>This does not substitute for a comprehensive examination</u> with your child's regular physician where important preventive health information can be covered.

<u>Athlete's Directions:</u> Please review all questions with your parent or legal custodian and answer them to the best of your knowledge.

<u>Parent's Directions:</u> 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.

<u>Physician's Directions:</u> 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.]? List:	❑	❑	❑
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. Does the athlete have the sickle cell trait?	❑	❑	❑
5. Has the athlete ever had a head injury, been knocked out, or had a concussion?	❑	❑	❑
6. Has the athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	❑	❑	❑
7. Has the athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	❑	❑	❑
8. Has the athlete ever fainted or passed out AFTER exercise?	❑	❑	❑
9. Has the athlete had extreme fatigue (been really tired) with exercise (different from other children)?	❑	❑	❑
10. Has the athlete ever had trouble breathing during exercise, or a cough with exercise?	❑	❑	❑
11. Has the athlete ever been diagnosed with exercise-induced asthma ?	❑	❑	❑
12. Has a doctor ever told the athlete that they have high blood pressure?	❑	❑	❑
13. Has a doctor ever told the athlete that they have a heart infection?	❑	❑	❑
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?	❑	❑	❑
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"?	❑	❑	❑
16. Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	❑	❑	❑
17. Has the athlete ever had a stinger, burner or pinched nerve?	❑	❑	❑
18. Has the athlete ever had any problems with their eyes or vision?	❑	❑	❑
19. 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			
20. Has the athlete ever had an eating disorder, or do you have any concerns about your eating habits or weight?	❑	❑	❑
21. Has the athlete ever been hospitalized or had surgery?	❑	❑	❑
22. Has the athlete had a medical problem or injury since their last evaluation?	❑	❑	❑
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: _____

_____

_____

_____

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.)

This form is approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee and the NCHSAA Board of Directors.
This form is reviewed annually, and was last updated April 2013.