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	e best o	of you	r			
 knowledge. Parent's Directions: Please assure that all questions are answered to the best of your knowledge. Not discless information may put your child at risk during sports activity. Physician's Directions: We recommend carefully reviewing these questions and clarifying any positive answered. 		ccurat	e			
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 ☐ Chest ☐ Hip ☐ Hand ☐ Foot ☐ Chest ☐ Chest ☐ Hand ☐ Foot ☐ Chest ☐ Ches						
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:						
	ore, I g	rive pe	rmission			
Signature of parent/legal custodian: Date:						
Signature of Athlete: Date: Phone #:						

Athlete's Name			Age Date of Birth
Height	Weight	BP	(% ile) / (% ile) Pulse
Vision R 20/I		Corrected: Y N	
			elements for all examinations
	NORMAL	ABNORMAL	ABNORMAL FINDINGS
PULSES	 	 	
HEART	+	 	
LUNGS		 	
SKIN NECK/DACK		 	
NECK/BACK		 	
SHOULDER		 	
KNEE		 	
ANKLE/FOOT		 	
Other Orthopedic			
Problems	Opti	ional Examination Ele	ements – Should be done if history indicates
HEENT	T		
ABDOMINAL			
GENITALIA (MALES)	T		
HERNIA (MALES)	T		
☐ C. Not cleared for:	Coll Non-con	llision	Contact IousModerately strenuousNon-strenuous
Additional Recommendations	s/Rehab Instruct	tions:	
Name of Physician/Extender: Signature of Physician/Extender (Signature and circle of designature	ıder		
Date of exam:		in cu,	Physician Office Stamp:
Address:			
Production			
Dhono		·	

^{(**} 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.)