NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION SPORT PREPARTICIPATION EXAMINATION FORM

Student Athlete's Name: _____ Age: _____ Sex: _____

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

<u>Student-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/Legal Custodian Directions:</u> Please assure that all questions are answered to the best of your knowledge. If you do not understand or are unsure about 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 "Yes" or "Unsure" answers.

Explain "Yes" or "Unsure" answers in the space provided below or on an attached separate sheet if needed.	Yes	No	Unsure
1. Does the student-athlete have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, etc.]? List:	❑	❑	❑
2. Is the student-athlete presently taking any medications or pills?	❑	❑	❑
3. Does the student-athlete have any allergies (medicine, bees or other stinging insects, latex)?	❑	❑	❑
4. Does the student-athlete have the sickle cell trait?	❑	❑	❑
5. Has the student-athlete ever had a head injury, been knocked out, or had a concussion?	❑	❑	❑
6. Has the student-athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	❑	❑	❑
7. Has the student-athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	❑	❑	❑
8. Has the student-athlete ever fainted or passed out AFTER exercise?	❑	❑	❑
9. Has the student-athlete had extreme fatigue (been really tired) with exercise (different from other children)?	❑	❑	❑
10. Has the student-athlete ever had trouble breathing during exercise, or a cough with exercise?	❑	❑	❑
11. Has the student-athlete ever been diagnosed with exercise-induced asthma?	❑	❑	❑
12. Has a doctor ever told the student-athlete that they have high blood pressure?	❑	❑	❑
13. Has a doctor ever told the student-athlete that they have a heart infection?	❑	❑	❑
14. Has a doctor ever ordered an EKG or other test for the student-athlete's heart, or has the athlete ever been told they have a heart murmur?	❑	❑	❑
15. Has the student-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 student-athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	❑	❑	❑
17. Has the student-athlete ever had a stinger, burner or pinched nerve?	❑	❑	❑
18. Has the student-athlete ever had any problems with their eyes or vision?	❑	❑	❑
19. Place a check beside each body part that the student-athlete has ever sprained/strained, dislocated, fractured, broken had repeated swelling in or had any other type of injury to any bones or joints? ❑ Head ❑ Shoulder ❑ Thigh ❑ Neck ❑ Elbow ❑ Knee ❑ Chest ❑ Hip ❑ Forearm ❑ Shin/calf ❑ Back ❑ Wrist ❑ Ankle ❑ Hand ❑ Foot Other: _____			
20. Has the student-athlete ever had an eating disorder, or are there concerns about his/her eating habits or weight?	❑	❑	❑
21. Has the student-athlete ever been hospitalized or had surgery?	❑	❑	❑
22. Has the student-athlete had a medical problem or injury since their last evaluation?	❑	❑	❑
23. (Place a check beside each statement that applies to the student-athlete, elaborate in the space provided below). ❑ 1. Has the student-athlete had little interest or pleasure in doing things? ❑ 2. Has the student-athlete been feeling down, depressed, or hopeless for more than 2 weeks in a row? ❑ 3. Has the student-athlete been feeling bad about himself/herself that they are a failure, or let their family down? ❑ 4. Has the student-athlete had thoughts that he/she would be better off dead or hurting themselves?			
FAMILY HISTORY			
24. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?	❑	❑	❑
25. Has any family member had unexplained heart attacks, fainting or seizures?	❑	❑	❑
26. Does the athlete have a father, mother or brother with sickle cell disease?	❑	❑	❑

Explain "yes" or "unsure" answers here: _____

_____

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: _____ Phone #: _____

Signature of Athlete: _____ Date: _____

(Rev. 3/2019) Approved for 2019-20 School Year

Student-Athlete's Name: _____**Age:** _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **BP**_____(____% ile) /_____(____% ile) **Pulse:** _____

Vision: R 20/_____**L 20/**_____**Corrected: Y N**

Physical Examination (Below Must be Completed by Licensed Physician, Nurse Practitioner or Physician Assistant)

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: _____ (Please print)

Signature of Physician/Extender: _____ MD DO PA NP (Please circle)

(Both signature and circle of designated degree required)

Date of Examination: _____

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.)

Novant Health – Sports Medicine
Student-Athlete Consents and Authorization Form

PARTICIPANT: **PLEASE READ CAREFULLY BEFORE SIGNING. THIS DOCUMENT HAS LEGAL CONSEQUENCES AND WILL AFFECT YOUR LEGAL RIGHTS AND ABILITY TO BRING FUTURE LEGAL ACTIONS.**

PERMISSION TO TREAT

I hereby give my consent and grant permission for medical treatment deemed necessary for any condition arising while participating in interscholastic sports, provided by Novant Health Sports Medicine athletic trainers ("ATCs"). This would include administration of medication(s) such as Albuterol or an Epipen to treat allergic reactions (e.g., anaphylactic reaction) or restrictive airway reactions (e.g., exercise-induced asthma) should such emergent need arise. If my injury/illness requires care not available on site, I understand every effort will be made to contact emergency contact prior to treatment being rendered at an off-site facility. I also grant permission for the ATC to release pertinent information to related health care providers, as well as those providers to release pertinent information to the ATC regarding care of my condition.

Signature of the Student-Athlete	Date
Printed	Date
Signature of the Parent/Legal Guardian (If student-athlete is under 18 years of age)	Date
Printed	Date

HIPAA AUTHORTIZATION

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and The Family Educational Rights and Privacy Act (FERPA) of 1974 require Novant Health to guard the privacy of your protected health information. You have the right to confidential treatment of all information and records pertaining to your care; as well as full consideration of privacy concerning your treatment and rehabilitation plan. You also have the right to be advised as to the reason for the presence of any individual during the course of your medical care. **If you sustain an injury while participating in interscholastic athletics at _____ ("School"), it is important to understand that Novant Health may need to discuss your injury with your coaches, assistant coaches, parents, and/or other people involved in your care. Novant Health may discuss issues relevant to your care only under the following circumstances:**

1. **You have given oral or implied consent through your actions.**
2. **You have signed the authorization form below, which permits us to disclose health information to the parties mentioned.**

Please note that even when you have signed this authorization allowing Novant Health to share your health information, it is important to know that Novant Health will only release the minimum amount of information necessary to protect you.

This authorizes the certified athletic trainers, physicians, sports medicine staff and other medical personnel representing Novant Health to release information concerning my medical status, medical condition, injuries,

prognosis, diagnosis and related personally identifiable health information to the coaches, assistant coaches, other athletics staff, my parents/guardians, and team personnel when deemed appropriate. This information includes injuries or illnesses related to past, present or future participation in athletics at School. I understand that once my health information is released, the recipients of my personal health information may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections. I have a right to receive a copy of this form upon request.

I understand that Novant Health will not receive any compensation for its use of the information. I understand that I may inspect or copy any information used under this authorization. I understand that I may cancel this authorization at any time by providing written notice to the Head Athletic Trainer in writing. Any cancellation will apply only to information not yet released by Novant Health. I understand that refusing to sign this form will not prevent my ability to get treatment. This authorization expires one year from the date it is signed.

_____ _____

Signature of the Student-Athlete Date

_____ _____

Signature of Parent/Legal Guardian (If student-athlete is under 18 years of age) Date

Legal Name of Participant _____Date of Birth _____

Address _____

Phone _____ Email _____

Have you ever been a patient at a Novant Facility or NH Physician? Yes____ No _____

Name of Primary Care Physician: _____

Medical Allergies: _____

Current Medications: _____

Past Serious Medical Conditions: _____

_____

Emergency Contact Information

Name: _____ Relationship: _____

Phone: _____ Alt Phone: _____