NORTH CAROLINA/RSS 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?			
2. Is the athlete presently taking any medication 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 she/he has high blood pressure?			
10. Has a doctor ever told the athlete that she/he has 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 She/he has a murmur?			
12. Has the athlete ever had discomfort, pain, or pressure in the chest during or after exercise or complained of his/her 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			
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: ____

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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/ ____________ **L20/** ____________ **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**

焮 A. Cleared

焮 B. Cleared after completing evaluation/rehabilitation for: ______________________________

焮 C. Not cleared for: 焮Collision 焮Contact

焮 Non-contact _____ Strenuous _____ Moderately strenuous _____ Non-strenuous

Due to: ______________________________

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Additional Recommendations/Rehab Instructions: ______________________________

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Name of Physician/Extender: ______________________________

Signature of Physician/Extender ______________________________ **MD DO PA NP**

(Signature and circle of designated degree required)

Date of exam: ____________________

Address: ______________________________

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Physician Office Stamp:

Phone: ____________________

**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 convulsion or concussions, absence of one kidney, eye, testicle or ovary, etc.

This form approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee December 2009, and the NCHSAA Board of Directors reviewed annually.