

NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION SPORT PREPARTICIPATION EXAMINATION FORM

Patient's Name: _____ Age: _____ Sex: _____

...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. 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.

Physician's Directions: 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: _____	<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. Does the athlete have the sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the athlete ever had a head injury, been knocked out, or had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. 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"/>
7. Has the athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the athlete ever fainted or passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the athlete had extreme fatigue (been really tired) with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has the athlete ever had trouble breathing during exercise, or a cough with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the athlete ever been diagnosed with exercise-induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has a doctor ever told the athlete that they have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has a doctor ever told the athlete that they have a heart infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Has the athlete ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Has the athlete ever had any problems with their eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Has the athlete ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints? <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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. 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"/>
21. Has the athlete ever been hospitalized or had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Has the athlete had a medical problem or injury since their last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<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: _____

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. 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, chronic growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver, 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.)
 This form approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee March 2011, and the NCHSAA Board of Directors reviewed annually.

Durham Public Schools

Assumptions of Risk/Medical Treatment Release

Student – Athlete Name _____
School _____
Sport(s) _____ Date _____

The Durham Public Schools system makes every effort to prevent injuries, but injuries do occur in athletics.

By signing below, I understand:

1. The Rules and procedures of the sport listed above and am aware of the risks involved in playing them
2. The necessity of using the proper techniques and protective equipment (when needed).

I recognize that there are inherent risks in all athletic events (head and spinal cord injuries, fractures, internal injuries, etc.) and hereby give my permission for my son/daughter to participate in any and all interscholastic events sponsored by Durham Public Schools.

Permission is hereby granted to Durham Public Schools and its authorized representative to initiate treatment and rehabilitation of injuries and authorize any needed major medical or minor surgical treatment, x-ray, examination, and immunization of the above named participating by appropriate medical personnel. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that every attempt will be made by the attending physician to contact me in the most expeditious manner possible. If said physician is unable to communicate with me, the treatment necessary for the best interest of the above named individual may be given.

I hereby release the Durham Public Schools system, local/individual school personnel, and the individual members of each athletic department including, but not limited to, its coaches, certified athletic trainers, student athletic trainers, athletic training student aides, administrators, attending physicians, and all other connected with school athletic activities, from any and all damages for injuries sustained by my son/daughter while participating in any sports activity associated with Durham Public Schools and do hereby agree to hold harmless any and all the above from any and all damages which they may suffer as a result of injuries sustained by my son/daughter while participating as above stated.

Are you presently taking any medications, supplements, or pills? Yes ___ No ___

If yes, please list: _____

Does student named above have allergies? Yes ___ No ___

(medicines, bee stings, hay fever, etc)

If yes, please list: _____

Phone # Primary _____ Secondary _____

Cell _____

Emergency Contact: Name _____

Primary # _____ Secondary _____

Signature: (Parent/Guardian): _____ Date _____

Please Read the Following Form Carefully

**Authorization For Release of Protected Health Information For Athletic Participating
In Durham Public Schools Athletics Program**

Once properly signed, this authorization will allow for the release of protected health information to the Durham Public Schools Systems (DPS) by physicians and health care providers (Providers) rendering services to DPS athletes. The purpose of the release of the protected health information is to allow the DPS Athletic Program to determine the advisability of an athlete's participation in DPS athletics. An example would be the release of a screening physical examination.

By signing this Authorization for my son, daughter or other person for whom I have legal authority to act (hereinafter referred to as "Athlete"), I hereby authorize health care providers (including, but not limited to, the Duke University Sports Medicine Program and its physicians and providers) that are contracted with DPS to release to each other and to the DPS oral and written medical information relating to the Athlete's medical or physical condition, illness or injury that may have a bearing upon past, present, or future participation in athletics of DPS Athletic Program. The medical information should be used by the DPS Athletic Program for the purpose of determining the advisability of the Athlete's participation in DPS athletics.

This authorization is expressly bound by all the following conditions:

This Authorization will automatically expire upon the Athlete's termination of participation or ineligibility in DPS Athletics, except to the extent relied upon for disclosures made prior to the automatic expiration.

This Authorization may be revoked at any time, provided the revocation *is a properly executed written document and delivered to the Director of Athletics for Durham Public Schools*. As soon as practicable, DPS shall inform each contracted health care provider prior of each Athlete's revocation. However, any such revocation shall not affect disclosures made by a health care provider prior to that health care provider's receipt of the revocation for DPS. In addition, such revocation shall not affect disclosures made prior to the receipt of the revocation to the extent that this Authorization was relied upon for such affect disclosures made prior to the receipt of the revocation to the extent that this Authorization was relied upon for such disclosures.

This Authorization is not intended to alter the Athlete's ability to receive medical care from any health care provider regardless of whether this Authorization is agreed to or refused.

This Authorization shall cover actions by and for Duke University, Duke University Health System, Inc. and Private Diagnostic Clinic, PLLC, and all of their respective employees, workforce, and business associates, and all other physicians and health care providers contracted with DPS and their respective employees, workforce, and business associates. For a complete list of contracted health care providers for DPS that may release medical information pursuant to the Authorization, please contact Durham Public Schools.

The athlete and Parent/Guardian will receive a complete copy of the signed Authorization.

A copy of this Authorization and any revocation of it will be kept by both the Duke Sports Medicine Office, Durham Public Schools and other health care providers contracted with Durham Public Schools.

Protected health information released by the health care providers to Durham Public Schools is not protected by this Authorization from re-disclosure by Durham Public Schools.

Date: _____

Parent/Guardian Signature

Printed Name

Relationship to Athlete

Athlete's Name - Printed

SPORTS MEDICINE
Student-Athlete Critical Contact Information

Today's Date: ____/____/____ School Year: _____

Name: _____ Class of: _____
 (Last) (First) (Middle)

Gender: M F Date of Birth: ____/____/____ Social Sec. # _____ School ID#: _____

Parent / Legal Custodian Information: (Social Sec. # Optional)

Father's Name _____ Father's Work # (____) _____

Employer _____ Father's Cell / Pager # (____) _____

Mother's Name _____ Mother's Work # (____) _____

Employer _____ Mother's Cell / Pager # (____) _____

Street Address _____ County: _____

City _____ State _____ Zip Code _____ Home Phone: (____) _____

Alternate Emergency Contact: _____ Phone: (____) _____

Athlete Medical Information:

1. Are you ALLERGIC to any type of medication? Y / N List: _____
2. List any other allergies: _____
3. Do you take medications regularly? Y / N List: _____
4. Do you take medicine for emergency use? Y / N List: _____
5. Do you have ASTHMA? Y / N If so, do you use an inhaler? Y / N What kind? _____
6. During athletic participation, do you wear: glasses? Y / N contacts? Y / N dental appliance? Y / N
7. Do you have any other medical conditions? Y / N List: _____
8. Have you ever had a head injury, been knocked out, or had a concussion? Y / N List: _____
9. Have you ever had discomfort, pain, or pressure in your chest during or after exercise or complained of your heart "racing" or "skipping beats"? Y / N List: _____

Family Physician: _____ Phone #: _____

Insurance Information

Provider Name: _____ Policy or Group # _____

Policy Holder's Name: _____ Phone # _____

Medical Authorization -- As the parents or legal custodian of this student athlete I grant permission for treatment deemed necessary for a condition arising during or affecting participation in sports, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment. Also, permission is granted to release medical information to the school and athletic trainer. This permission is valid during the entire duration of the student-athlete's enrollment at Rogers-Herr Middle School, unless revoked by me in writing.

Risk of Injury -- We acknowledge and understand that there is a risk of injury in athletic participation. We understand that the student-athlete will be under the supervision and direction of a DPS athletic coach. We agree to follow the rules of the sport 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 the DPS 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.

 Student-Athlete (Print):

 (Signature):

 Date:

 Parent / Legal Custodian (Print):

 (Signature):

 Date:

Durham Public Schools

Student Athlete Pledge

As a student athlete, I am a role model. Using inappropriate language; taunting; baiting; or the use of unwarranted physical contact directed at opposing players, coaches, and fans are contrary to the spirit of fair play and the good sportsmanship my school, my conference, and the NCHSAA expects of its members.

I accept my responsibility to model good sportsmanship that comes with being a student athlete.

Student Athlete Signature

Date

ACKNOWLEDGMENT FORM

It is the responsibility of the parents and students to read the **Rogers-Herr Middle School Parent-Student-Coach Interscholastic Athletic Handbook** prior to participating in our interscholastic athletic program. The information contained in this handbook outlines the Policies, Rules and Regulations that govern our program. The school district requires that you and your student-athlete sign this Acknowledgment Form and return it to your son/daughter's coach. Please return the form as soon as possible. **No student athlete will be allowed to participate in a game until this form is returned.** I/we have read the Rogers-Herr Middle School Parent-Student-Coach Interscholastic Athletic Handbook and understand the Policies, Rules and Regulations that govern the program. I have read the **Athlete Code of Conduct** and thoroughly understand the consequences that I will face if I do not honor my commitment to the **Athlete Code of Conduct**.

If a coach feels a student-athlete has violated the Athlete Code of Conduct, a team rule, or has accumulated an excessive number of unexcused absences that would result in a suspension or dismissal from a team, the coach will contact the Athletic Director and submit his/her recommendation for disciplinary action. The Athletic Director, after consultation with the Principal, and after discussing the circumstances with parents, shall render a decision.

Print Name of Student-Athlete Season

Date

Student-Athlete Signature

Date

Parent/Guardian Signature

Date

PLEASE RETURN THIS FORM TO YOUR COACH