NEW HANOVER COUNTY SCHOOLS PRE-PARTICIPATION SPORTS SCREENING

(IN ACCORDANCE WITH NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION GUIDELINES)

Student's Name: _____ Date of Birth: _____ Grade: _____

Address: _____

Phone: _____ School: _____ Personal Physician: _____

Sex: _____ Age: _____ Sports: _____

In case of emergency, contact: _____ Phone: _____ Relationship: _____

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.

Parents & Students, please review all questions and answer them 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 the student at risk during sports activity. Please explain "Yes" answers below. Physicians, we recommend carefully reviewing these questions and clarifying any positive answers.	**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? GW Awareness Concussion Act	❑	❑	❑
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 has 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, 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 a parent or legal custodian, I give permission for my child to participate in sports.

Signature of parent/legal custodian: _____ Date: _____

Signature of Athlete: _____ Date: _____ Phone #: _____

(over)

NEW HANOVER COUNTY SCHOOLS PRE-PARTICIPATION SPORTS SCREENING

(Must be completed by a Licensed Physician, Nurse Practitioner or Physician's Assistant)

Student's Name: _____ School: _____ Date of Birth: _____

Height _____ **Weight** _____ **BP** _____/ _____ **BP** _____/ _____ **Pulse** _____

Vision R 20/_____ **L 20/**_____ **Corrected: Yes No**

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, 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. This form approved by the NCHSAA Sports Medicine Advisory Committee April 2013, and then modified by NHCS August 2013.