2019 Gaston County Sports Physical Day

SPORT PRE-PARTICIPATION EXAMINATION FORM (Modified NCHSAA Form)

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

2019-2020 School: Piedmont Community Charter School

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.

Explain "Yes" answers below	Yes	No	Don't Know
1. Does the athlete have any chronic medical illness [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?			
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. Had the athlete ever had a 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 had 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. Had 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 ___Forearm ___Shin/calf ___Back ___Wrist ___Ankle ___Hand ___Foot ___Hip			
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/been: 1. Little interest or pleasure in doing things; 2. Feeling down, depressed, or hopeless for more than 2 weeks in a row; 3. Feeling bad about himself/herself that they are a failure, or let their family down; 4.Thoughts that he/she would be better off dead or hurting themselves?			
23. Has the athlete had a medical problem or injury since their last evaluation?			
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?			

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, I give permission for my child to participate in sports. I understand that this examination is a limited screening and does not substitute for your yearly wellness check up with my child's family physician. I further understand that the examination is being performed by a volunteer medical provider and that under North Carolina law, a volunteer medical or health care provider shall not be liable for damages for injuries or death alleged to have occurred by reason of an act or omission in the medical or health care provider's voluntary provision of health care services unless it is established that the injuries or death were caused by gross negligence, wanton conduct, or intentional wrongdoing on the part of the volunteer medical or health care provider.

Signature of parent/legal custodian: _____ Date: _____

Signature of Athlete: _____ Date: _____

Athlete's Name:_____DOB:_____

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

Height:_____ Weight:_____ Initial BP:____/____ BP Recheck:____/____ BP Recheck2:____/_____ Pulse:_____
Staff:_____ Staff:_____ Staff:_____
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. 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:_____

Orthopedic Physician/Extender:_____Signature:_____MD PA

Primary Care Physician/Extender:_____Signature:_____MD D O PA NP

(Signature and circle of designated degree required)

Date of Exam:_____

Address:_____

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, 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.) This form is approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee and theNCHSAA Board of Directors. Rev: May 2016 Page 2 of 2 Approved for 2019-20 School Year