

NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION SPORT PREPARTICIPATION EXAMINATION FORM

Patient's Name: _____ Date of birth: _____ Age: _____ Sex: _____

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. 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/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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Has the athlete had a medical problem or injury since their last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FAMILY HISTORY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. 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"/>
25. Has any family member had unexplained heart attacks, fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. 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: _____

If additional space is needed attach a separate sheet

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 #: _____

*Current form as of April 2016

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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: _____

Signature of Physician/Extender _____ MD DO PA NP

(Signature and circle of designated degree required)

Date of exam: _____

Address: _____

Phone _____

Physician Office Stamp:

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(*** 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 the NCHSAA Board of Directors.

This form is current as of April 2016

Student-Athlete & Parent/Legal Custodian Concussion Statement

**If there is anything on this sheet that you do not understand, please ask an adult to explain or read it to you.*

Student-Athlete Name: _____

This form must be completed for each student-athlete, even if there are multiple student-athletes in each household.

Parent/Legal Custodian Name(s): _____

- We have read the *Student-Athlete & Parent/Legal Custodian Concussion Information Sheet*.
If true, please check box.

After reading the information sheet, I am aware of the following information:

Student-Athlete Initials		Parent/Legal Custodian Initials
	A concussion is a brain injury, which should be reported to my parents, my coach(es), or a medical professional if one is available.	
	A concussion can affect the ability to perform everyday activities such as the ability to think, balance, and classroom performance.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach, and/or a medical professional about my injuries and illnesses.	N/A
	If I think a teammate has a concussion, I should tell my coach(es), parents, or medical professional about the concussion.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	I will/my child will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away right away. I realize that resolution from this injury is a process and may require more than one medical evaluation.	
	I realize that ER/Urgent Care physicians will not provide clearance if seen right away after the injury.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms on the Concussion Information Sheet.	

Signature of Student-Athlete

Date

Signature of Parent/Legal Custodian

Date

CONCUSSION

INFORMATION FOR *STUDENT-ATHLETES & PARENTS/LEGAL CUSTODIANS*

What is a concussion? A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

How do I know if I have a concussion? There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Headache	Irritability-things bother you more easily	Sleeping more than usual
Taking longer to figure things out	Fuzzy or blurry vision	Sadness	Sleeping less than usual
Difficulty concentrating	Feeling sick to your stomach/queasy	Being more moody	Trouble falling asleep
Difficulty remembering new information	Vomiting/throwing up	Feeling nervous or worried	Feeling tired
	Dizziness	Crying more	
	Balance problems		
	Sensitivity to noise or light		

Table is adapted from the Centers for Disease Control and Prevention (<http://www.cdc.gov/concussion/>)

What should I do if I think I have a concussion? If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

When should I be particularly concerned? If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

What are some of the problems that may affect me after a concussion? You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur. Once you have a concussion, you are more likely to have another concussion.

How do I know when it's ok to return to physical activity and my sport after a concussion? After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign your brain has not recovered from the injury.

This information is provided to you by the UNC Matthew Gfeller Sport-Related TBI Research Center, North Carolina Medical Society, North Carolina Athletic Trainers' Association, Brain Injury Association of North Carolina, North Carolina Neuropsychological Society, and North Carolina High School Athletic Association.

PARENT CONSENT FOR EXAMINATION & TREATMENT

(This must be completed yearly in order for your child to participate in sports for Swain County)

One MUST be filled out on EACH Athlete

Athlete Name _____ Date of birth _____ Age _____

School _____ Grade (in upcoming Fall semester) _____

Parent/Guardian Name _____

Home Address _____

Home Phone (____) _____ Cell Phone (____) _____

Work Phone (____) _____ Other Phone (____) _____

Insurance Information _____

Policy # _____

Emergency Contact Person _____ Phone (____) _____

Family Physician _____ Phone (____) _____

PRE-SCREENING PHYSICAL (if my child when through the "free sports physical" for Swain County): I hereby give my informed consent for the participating physician(s) to perform a pre-participation screen physical examination on my child. I realize that this is only a screening examination and does not take the place of a complete examination. During a screening, the physician is not responsible for any ongoing medical care or treatment of any injuries that occur on the day of the examination or subsequently. My child has no known serious medical conditions that would prevent him/her from participating in sports that I am aware of. I agree to follow up with my local physician if anything preventing participation is found by the screening.

EMERGENCY TREATMENT: In the event of a medical emergency, every attempt to notify the parent or guardian will be made. However, if you cannot be reached, we ask that you grant permission for your child to be treated for a medical emergency by a licensed physician, certified athletic trainer or any other person trained in emergency care. In the event that I cannot be reached, I grant permission to the SWAIN COUNTY SCHOOLS / CAROLINA WEST / HARRIS REGIONAL HOSPITAL OTHOPEDIC & SPORTS MEDICINE to provide emergency medical treatment to my son or daughter (named above) by a licensed medical physician.

PRACTICE / GAME INJURY CLINIC TREATMENT CONSENT: Local, licensed physicians will be serving as our team physicians when possible. We ask that you sign and give permission to these physicians to treat your son or daughter for any sports related injury. I understand that no surgical procedures will be performed without my further consent.

Please Turn Over and read/sign the back of form.
Thank You!

ATHLETIC TRAINING SERVICES CONSENT: Nationally certified and stated licensed athletic trainers will be providing prevention and care of athletic injuries to the Swain County Schools student athletes. The prevention of athletic injuries may include the taping, wrapping, padding or bracing of involved / injured areas. The treatment and care of athletic injuries may include, but not limited to (if available) the use of therapeutic modalities. Some possible modalities available for use by the athletic trainers may include (if available to the athletic trainer): Kinesio taping, ice, moist heat pack, therapeutic ultrasound, cold laser therapy, and electrical stimulation, etc... In the event of a possible concussion the athletic trainer will need to do extensive testing which could include, but not limited to ImPACT, SCAT, BESS, etc... By signing below you give permission to the certified athletic trainer to provide athletic training services to provide care, use modalities if available (listed above), and treatment for any sports related injury.

ATHLETIC TRAINING CONSENT: During an injury the certified athletic trainer will do everything they can to quickly inform you of any sports related injury and the care that will be needed. However, the environment in which the athletic trainer works in is one that is very different then the controlled environment of a hospital or clinic/office, so if your child gets injured during a game or practice and you (as the parent/guardian) want to know about your child's injury you need to be aware that there are often other people that are around in the area that can overhear what the athletic trainer is saying. If you want a more controlled setting for the athletic trainer to talk with you without other people around to hear the medical information regarding your child's injury (as the parent/guardian) you will need to make this request known to the athletic trainer prior to the athletic trainer informing you of the injury. If you allow the athletic trainer to inform you regarding your child's injury in an uncontrolled environment, with other people around that could overhear the conversation – if you allow this then you are releasing the athletic trainer from ALL HIPAA (Health Insurance Portability and Accountability Act) accounts and cannot hold the athletic trainer accountable for other people overhearing medical information regarding your child's injury.

Also because the athletic trainer works diligently with your child's coach(es) and in order to provide the best care for your child, the athletic trainer will need to inform your child's coach(es) of certain information; in order for your child's coach and the athletic trainer to know how to best work with your child's sport and injury. The athletic trainer will keep your child's information told to a coach(es) to the most minimum amount possible; however, information that could be told to a coach(es) could include, but not limited to: they area of injury, the type of injury, the extent of injury, if there is/was possible surgery involve, if there is/was physical therapy involvement, when your child has/had an appointment with a doctor, dates for scheduled test(s)/exams(s) (ie: MRI/CT/ect...) the possible length of time your child could be out or limited for practice(s) and/or games/ and/or over if the injury could affect your child's next sports seasons. The overall extent of the injury, etc... is the type of information that may need to be made known to your child's coach(es). By signing below you are aware this type of information will need to be shared with your child's coach(es) and you are releasing the athletic trainer from HIPAA (Health Insurance Portability and Accountability Act) accounts by giving your permission for the athletic trainer to share the needed information to your child's coach(es).

I have fully read and consent to all the above. I have had all my questions answered to my fullest satisfaction, and I fully understand, and agree with the information above. By signing below (1) I am giving my full permission/consent to the information above and (2) release Swain County's ATHLETIC TRAINER / SWAIN COUNTY SCHOOLS / CAROLINA WEST/HARRIS REGIONAL HOSPITAL OTHOPEDIC & SPORTS MEDICINE regarding the information stated above.

Parent / Guardian Signature

Date

Parent / Guardian PRINT name