NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION
SPORT PREPARTICIPATION EXAMINATION FORM

Patient’s Name: __________________________________ Age: _____ Sex: __________

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
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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 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 [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: _________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

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 at Gaston Christian School.

Signature of parent/legal custodian: ____________________________________________ Date: ______________

Signature of Athlete: ____________________________________________ Date: ______________
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/____  L 20/_____  Corrected: Y/N

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<th>NORMAL</th>
<th>ABNORMAL</th>
<th>ABNORMAL FINDINGS</th>
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<td>Other Orthopedic Problems</td>
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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  OD  PA  NP
(Signature and circle of designated degree required)

Date of Exam: ______________________________  Physician Office Stamp

Address: ______________________________________________

Phone: ______________________________________________