

NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION SPORT PREPARTICIPATION EXAMINATION FORM

Patient's Name: _____ Age: _____

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. 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 answers.

| Explain "Yes" answers below | Yes | No | Don't know |
|--|--------------------------|--------------------------|--------------------------|
| 1. Has the athlete ever been hospitalized or had surgery? | <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. Has the athlete ever passed out or nearly passed out DURING exercise, emotion or startle? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has the athlete ever fainted or passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has the athlete had extreme fatigue associated with exercise (different from other children)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Has the athlete ever had trouble breathing during exercise, or a cough with exercise? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has the athlete ever been diagnosed with exercise-induced asthma? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a doctor ever told the athlete that they have high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a doctor ever told the athlete that they have a heart infection? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. 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"/> |
| 12. 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"/> |
| 13. Has the athlete ever had a head injury, been knocked out, or had a concussion? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Has the athlete ever had a stinger, burner or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. 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"/> |
| 17. Has the athlete ever had any problems with their eyes or vision? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Has the athlete ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <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 | | | |
| 19. 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"/> |
| 20. Does the athlete have any chronic medical illnesses (diabetes, asthma, kidney problems, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Has the athlete had a medical problem or injury since their last evaluation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Does the athlete have the sickle cell trait? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| FAMILY HISTORY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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: _____

I have reviewed and answered each question above, and assure that all are accurate responses. Furthermore, I 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's 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 _____

| |
|---------------------------------------|
| <p>Physician Office Stamp:</p> |
|---------------------------------------|

(** 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.)

PLEASE READ THE FOLLOWING FORM CAREFULLY
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR ATHLETES PARTICIPATING
IN ORANGE COUNTY SCHOOL ATHLETICS

Once properly signed, this Authorization will allow for the release of protected health information to the Orange County Schools ("OCS") by physicians and health care providers ("providers") rendering services to OCS athletes. The purpose of the release of the protected health information is to allow the OCS to determine the advisability of an athlete's participation in OCS 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 the 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 the OCS to release to each other and to the OCS 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 the OCS. The medical information should be used by the OCS for the purpose of determining the advisability of the Athlete's participation in OCS athletics.

This Authorization is expressly bound by all the following conditions:

- i. This Authorization will automatically expire upon the Athlete's termination of participation or ineligibility in OCS Athletic: except to the extent relied upon for disclosures made prior to the automatic expiration.
- ii. 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 OCS**. As soon as practicable, the OCS shall inform each contracted health care provider 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 from the OCS. 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 disclosures.
- iii. 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.
- iv. This Authorization shall cover actions by and for Duke University, Duke University Health System, Inc. and the Private Diagnostic Clinic, PLLC, and all of their respective employees, workforce, and business associates, and all other physicians and health care providers contracted with OCS and their respective employees, workforce, and business associates. For a complete list of contracted health care providers of the OCS that may release medical information pursuant to the Authorization, please contact the OCS.
- v. The athlete and Parent / Guardian will receive a complete copy of the signed Authorization.
- vi. A copy of this Authorization and any revocation of it will be kept by both the Duke Sports Medicine Office, the OCS, and other health care providers contracted with the OCS.
- vii. Protected health information released by the health care providers to the OCS is not protected by this Authorization from re-disclosure by the OCS.

DATE: _____

PARENT / GUARDIAN* (signed)

(Printed Name) / (Relationship to Athlete)

Athlete's Name (Printed)

*This Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the Athlete's behalf. **By signing this form, you as the parent, guardian, or a party acting in loco parentis warrant that you have the legal authority to act on the Athlete's behalf.**

*The signature may be only the Athlete if the Athlete is over 18 years of age or a legally emancipated person.