

North Carolina Sport Pre-Participation Examination Form

Instructions: 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.

- **Athletes:** Please review all questions with your parent or legal custodian and answer them to the best of your knowledge.
- **Parents:** Please assure that all questions are answered to the best of your knowledge. If you do not understand or are unsure about the answer to a question please ask your doctor. Not disclosing accurate information may put your child at risk during sports activity.
- **Physicians:** We recommend carefully reviewing these questions and clarifying any "yes" or "unsure" answers.

Patient's Name: _____ Age: _____ Sex: _____

Explain "Yes" or "Unsure" answers below

	Yes	No	Unsure
Does the athlete have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, migraine, etc.]? List: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the athlete presently taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the athlete have any allergies (medicine, bees or other stinging insects, latex)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the athlete have the sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the athlete ever had a head injury, been knocked out, or had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
Has the athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the athlete ever fainted or passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the athlete had extreme fatigue (been really tired) with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the athlete ever had trouble breathing during exercise, or a cough with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the athlete ever been diagnosed with exercise-induced asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a doctor ever told the athlete that they have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a doctor ever told the athlete that they have a heart infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the athlete ever been told they have a murmur or had an EKG or other test ordered for the athlete's heart?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the athlete ever had discomfort, pain, or pressure in their chest during or after exercise or complained of their heart "racing" or "skipping beats"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the athlete ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the athlete ever had any problems with their eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/> Forearm <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"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the athlete ever had an eating disorder, or are there concerns over their eating habits or weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the athlete ever been hospitalized or had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the athlete had a medical problem or injury since their last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the athlete had a medical problem or injury since their last evaluation? 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 or others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
Has any family member had unexplained heart attacks, fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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) or "unsure" 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: _____

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Instructions: This form must be completed by a licensed physician, nurse practitioner or physician assistant.

Athlete's Name _____ Age _____ Date of Birth _____
 Height _____ Weight _____ BP _____ (_____ % ile) / _____ (_____ % ile) Pulse _____
 Vision R 20/ _____ L 20/ _____ Corrected: Y N Sport(s): _____

These are required elements for all examinations

	NORMAL	ABNORMAL	ABNORMAL FINDINGS
Pulses			
Heart			
Lungs			
Skin			
Neck/Back			
Shoulders			
Knees			
Ankles/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: _____

(*** 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.)

Name of Physician/Extender: _____

Signature of Physician/Extender _____ MD DO PA NP
 (Signature and circle of designated degree required)

Physician Office Stamp:	Date of exam: _____ Address: _____ _____ Phone: _____
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