NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION SPORT PREPARTICIPATION EXAMINATION FORM

Student Athlete's Name: ______________________ 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.*

Student-Athlete's Directions: Please review all questions with your parent or legal custodian and answer them to the best of your knowledge.

Parent/Legal Custodian Directions: 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.

Physician's Directions: We recommend carefully reviewing these questions and clarifying any "Yes" or "Unsure" answers.

Explain "Yes" or "Unsure" answers in the space provided below or on an attached separate sheet if needed.	Yes	No	Unsure
1. Does the student-athlete have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, etc.]? List:	☐	☐	☐
2. Is the student-athlete presently taking any medications or pills?	☐	☐	☐
3. Does the student-athlete have any allergies (medicine, bees or other stinging insects, latex)?	☐	☐	☐
4. Does the student-athlete have the sickle cell trait?	☐	☐	☐
5. Has the student-athlete ever had a head injury, been knocked out, or had a concussion?	☐	☐	☐
6. Has the student-athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	☐	☐	☐
7. Has the student-athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	☐	☐	☐
8. Has the student-athlete ever fainted or passed out AFTER exercise?	☐	☐	☐
9. Has the student-athlete had extreme fatigue (been really tired) with exercise (different from other children)?	☐	☐	☐
10. Has the student-athlete ever had trouble breathing during exercise, or a cough with exercise?	☐	☐	☐
11. Has the student-athlete ever been diagnosed with exercise-induced asthma?	☐	☐	☐
12. Has a doctor ever told the student-athlete that they have high blood pressure?	☐	☐	☐
13. Has a doctor ever told the student-athlete that they have a heart infection?	☐	☐	☐
14. Has a doctor ever ordered an EKG or other test for the student-athlete's heart, or has the athlete ever been told they have a heart murmur?	☐	☐	☐
15. Has the student-athlete ever had discomfort, pain, or pressure in his chest during or after exercise or complained of their heart "racing" or "skipping beats"?	☐	☐	☐
16. Has the student-athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	☐	☐	☐
17. Has the student-athlete ever had a stinger, burner or pinched nerve?	☐	☐	☐
18. Has the student-athlete ever had any problems with their eyes or vision?	☐	☐	☐
19. Place a check beside each body part that the student-athlete has ever sprained/strained, dislocated, fractured, broken had repeated swelling in or had any other type of injury to any bones or joints? ☐ Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Elbow ☐ Knee ☐ Chest ☐ Hip ☐ Forearm ☐ Shin/calf ☐ Back ☐ Wrist ☐ Ankle ☐ Hand ☐ Foot Other:			
20. Has the student-athlete ever had an eating disorder, or are there concerns about his/her eating habits or weight?	☐	☐	☐
21. Has the student-athlete ever been hospitalized or had surgery?	☐	☐	☐
22. Has the student-athlete had a medical problem or injury since their last evaluation?	☐	☐	☐
23. (Place a check beside each statement that applies to the student-athlete, elaborate in the space provided below). ☐ 1. Has the student-athlete had little interest or pleasure in doing things? ☐ 2. Has the student-athlete been feeling down, depressed, or hopeless for more than 2 weeks in a row? ☐ 3. Has the student-athlete been feeling bad about himself/herself that they are a failure, or let their family down? ☐ 4. Has the student-athlete had thoughts that he/she would be better off dead or hurting themselves?			
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?	☐	☐	☐

Explain "yes" or "unsure" answers here: ______________________________

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: __________ Phone #: ______________

Signature of Athlete: ______________________ Date: __________

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Approved for 2018-19 School Year

Student-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: ______________________ (Please print)

Signature of Physician/Extender: ______________________ MD DO PA NP (Please circle)

(Both signature and circle of designated degree required)

Date of Examination: ______________________

Address: ______________________

Phone: ______________________

Physician Office Stamp

(*** 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.

Rev: March 2018

Approved for 2018-19 School Year

Sports Medicine Program Consent for Medical Care and Treatment

I, ____________________, the parent/legal guardian of ____________________, a student at Mountain Heritage High School whose date of birth is ________________, authorize Mission Health System, Inc. and each of its affiliated, participating hospitals as applicable including Mission Hospital, Inc., Blue Ridge Regional Hospital, Inc., Mission Hospital McDowell, Inc., Angel Medical Center, Inc., Highlands-Cashiers Hospital, Inc. and Transylvania Community Hospital, Inc. (collectively and/or individually as is applicable referred to herein as "Mission") and associated staff to provide my child such healthcare or other services offered by the Sports Medicine Program and, where appropriate, to make referrals for my child to receive additional health services that my child's condition may indicate. *In any such event, student athletes and their parents/legal guardians shall have the option to choose any medical provider as they and/or their legal guardian(s) may choose, as many options are available to student athletes. No student and/or his or her parents/guardians are required to utilize Mission for medical services.*

Pre-Participation Physical. I hereby give my consent/permission to Mission and participating, licensed or other medical providers to perform a pre-participation screening physical examination ('screening exam') for my child. I agree that this screening exam is only a limited, screening examination and does not take the place of a complete medical examination. I understand and agree that the medical provider(s) completing the screening exam shall not be responsible for any ongoing medical care or treatment for any medical condition or for injuries that occur after the screening exam. I represent, to the best of my knowledge, that my child has no known medical condition that would prevent participation in sports. I agree to follow up with my child's primary care provider in the event that any medical condition is identified in the screening exam.

Injury and/or Emergency Treatment: In the event that it becomes necessary, I agree that the team physician or athletic trainer, as appropriate, may provide medical care and/or treatment to my child as provided herein for a sports-related injury. In addition, in the event my child needs urgent or emergency treatment, I authorize the staff of the School and/or Mission, where appropriate, to arrange for such care with appropriate providers, including appropriate transportation. In such instance, I authorize the School and/or Mission, where appropriate, to undertake any acts which may be necessary or proper to provide for the health care of the minor child named herein, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures. By signing below, I indicate that I have the understanding and capacity to communicate health care decisions on behalf of the child named herein and that I understand the contents of this document. I understand that the School staff and/or the Mission staff, as appropriate, will contact me as soon as possible in the event my child has an urgent or emergency condition.

Payment for Services Rendered. I understand that I will not be charged by Mission for services rendered on-site by the Mission Athletic Trainer or other Mission Sports Medicine staff assigned to the school but that I or my insurance carrier may be charged for services rendered by other healthcare providers for follow-up care or treatment.

Health Information. I agree to complete all health history, family history, and other informational requests necessary for my child's participation in the School's athletic events and as required for medical care and treatment or other services provided by Mission. I understand that I may contact the Mission Athletic Trainer or the Team Physician assigned to the School or the Mission Medical Director to discuss my child's care or to discuss any questions that I may have about the program.

Neurocognitive Testing. I understand and agree that my child may undergo a computerized concussion evaluation system, such as ImPACT, as part of an overall concussion management protocol. https://www.impacttest.com/about

Students. I understand and agree that Mission is involved in the education of student athletic trainers (at the college level and student aides at the high school level), physicians, nurses, technicians and other health care providers, interns, and observers. I understand and agree that these individuals may participate as is appropriate in providing athletic training, medical care and/or treatment to my child as provided herein for a sports-related injury or otherwise.

Medication. Athletic Trainers are not responsible for an athlete's prescription or non- prescription medication(s). An athletic trainer may, under the supervision and protocol of a provider, receive, store, and administer medication to my child and/or store my child's medication for the duration of an athletic event upon my request.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE AND CONSENT TO MY CHILD'S PARTICIPATION IN THE MISSION SPORTS MEDICINE PROGRAM AND TO THE OTHER TERMS AND CONDITIONS CONTAINED HEREIN. I HEREBY CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF THE CHILD NAMED HEREIN.

Name of Parent/Legal Guardian (Please Print) ____________________ Name of Student (Please Print) ____________________

Signature of Parent/Legal Guardian ____________________ Relationship to Student ____________________

Date of Signature: ____________________

AUTHORIZATION FOR ACCESS, USE, OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ____________________, the parent/legal guardian of ________________, a student at Mountain Heritage High School, whose date of birth is ____________, authorize Mission Health System, Inc. and each of its affiliated, participating hospitals as applicable including Mission Hospital, Inc., Blue Ridge Regional Hospital, Inc., Mission Hospital McDowell, Inc., Angel Medical Center, Inc., Highlands-Cashiers Hospital, Inc. and Transylvania Community Hospital, Inc. (collectively and/or individually as is applicable referred to herein as "Mission") consent to and authorize the release by Mission of information about my child's medical condition obtained through the Sports Medicine Program to the School's named coaches and other employees or agents of the School. I also specifically consent to and authorize the sharing of my child's medical information among the Mission Sports Medicine staff (team physicians, if any, other medical staff/providers, athletic trainers, and any student assistants) and the School's athletic staff, teachers/coaches, and school administration.

My signature below indicates that I understand and agree to the following:

1. This authorization for the release of my health information is voluntary, which means I do not have to authorize this release or sign this form.
2. As applicable, this release may include information related to behavioral/mental health, drug and alcohol abuse treatment, genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
3. My decision to sign this authorization will not have an effect on the treatment provided to my child by any applicable health care provider, the cost of that treatment, or any benefits.
4. I may revoke this authorization at any time by notifying Mission in writing.
5. Revoking this authorization will not affect any disclosures made prior to revoking this authorization.
6. Unless revoked or an expiration date is indicated here ________, this authorization will extend until the end of the athletic season for which my child is engaged (2018-2019 athletic year).
7. After release my information may no longer be protected by privacy regulations, which means the person receiving may be able to share that information without my permission.
8. Mission will not use or share my health information without my permission, except as allowed or required by law.
9. This form will not be used for marketing or research.
10. A fee may be charged for providing any requested medical records.
11. I may ask for and get a copy of this authorization. A readable photocopy/fax of this authorization shall have the same force and effect as the original.

I hereby authorize the access, use or disclosure of my child's health information as described in this form.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO THE TERMS AND CONDITIONS CONTAINED HEREIN. I HEREBY CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF THE CHILD NAMED HEREIN.

____________________ Name of Parent/Legal Guardian (Please Print) ____________________ Name of Student (Please Print)

____________________ Signature of Parent/Legal Guardian ____________________ Relationship to Student

Date of Signature: ____________________