

Sports Participation History Form

Patient's Name: _____ Age: _____

Date of Birth: _____ Race: _____ Sex: _____ SS#: _____

Grade: _____ School: _____ Sports: _____

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

Physician's Directions: We recommend repeating the thirteen questions listed below and carefully reviewing details of any positive answers.

YES	NO	
		Has anyone in the athlete's family (grandmother, grandfather, mother, father, brother, sister) died suddenly before age 50?
		Has the athlete ever stopped exercising because of dizziness or passed out during exercise?
		Has the athlete ever been told he/she has a heart murmur or heart problem?
		Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?
		Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?
		Does the athlete have a history of a concussion (getting knocked out)?
		Has the athlete ever suffered a heat-related illness (heat stroke)?
		Does the athlete have anything he/she wants to talk about to the doctor?
		Does the athlete have a chronic illness or see a doctor regularly for any particular problem?
		Does the athlete take any medicine?
		Is the athlete allergic to any medications or bee stings?
		Does the athlete have only one of any paired organs (eyes, ears, kidneys, testicles, ovaries, etc.)?
		Does the athlete wear contacts or eyeglasses?
		Date of last Tetanus booster, DATE _____

Elaborate on any positive answer:

I have answered and reviewed the questions above and give permission for my child to participate in sports.

Signature of Parent/Guardian: _____ Date: _____

Phone #: _____

The Sports Participation Evaluations are basic exams and in no way replace the specific issues and examinations addressed in a well child physical.

EXAMINATION

Patient's Name: _____

1. BP_____/_____ WT_____ HT_____ Vision (R) _____(L)_____

2. Musculoskeletal Exam

	Normal	Abnormal	Record (laxity, weakness, instability, decreased ROM – if abnormal)
Neck			
Knee			
Ankle			
Shoulder			
Feet			
Scoliosis/Spine			
Other Orthopedic Problems			

3. Cardiovascular Exam

	Normal	Abnormal	Not Done	Comments
ENT				
Chest				
Abdomen				
Genitalia				
Skin				

4. **Assessment:** _____ No problems identified _____ Other:_____5. **Recommendations:** _____ Unlimited _____ Limited to specific sports
_____ Deferred until: (e.g., rehab, recheck, consultation, lab, etc)6. **Re-Exam:** _____ Yearly and after any injury that limits participation for great than one (1) week.
_____ Other_____I certify that I have examined the above student and that such examination revealed
_____ Conditions _____ No Conditions that would prevent this student from participation in interscholastic sports.

Licensed to practice medicine in North Carolina? _____ Yes _____ No

Signature:_____ Phone #:_____ Date:_____

Address: _____

If student is not qualified, list reasons for disqualification:_____

(The following are considered disqualifying until medical conditions and parental released are obtained: acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, hernia, musculoskeletal deformity associated with functional loss, history of convulsions or concussions, absence of one kidney, eye, testicle, or ovary, etc.)