SPORT PREPARTICIPATION HISTORY FORM

FORM CURRENTLY RECOMMENDED BY NCMS SPORTS MEDICINE COMMITTEE (7/93)

Patient's Name:____ Age: _______________

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	DON'T KNOW		
			1.	Has anyone in the athlete's family (grandmother, grandfather, mother, father, brother, sister) died suddenly before the age of 50?
			2a.	Has the athlete ever stopped exercising because of dizziness or passed out during exercise?
			2b.	Have you ever been told you have a heart murmur or heart problems?
			3.	Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?
			4.	Has the athlete ever had a bone broken, had to wear a cast, or had an injury to any joint?
			5.	Does the athlete have a history of concussion (getting knocked out)?
			6.	Has the athlete ever suffered a heat-related illness (heat stroke or heat exhaustion)?
			7.	Does the athlete have anything he/she wants to talk to the doctor about?
			8.	Does the athlete have a chronic illness or see a doctor regularly for any particular problem?
			9.	Does the athlete take any medicine?
			10.	Is the athlete allergic to any medications or bee stings?
			11.	Does the athlete have only one of any paired organ? (eyes, ears, kidneys, testicles, ovaries, etc.)?
			12.	Do you wear contacts or eye glasses?
			13.	Date of last tetanus booster. DATE:

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Elaborate on any positive answers:

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

Signature of Parent or Guardian: ____

Address: ____

Date ______________________________ Phone # ______________________________

EXAMINATION

PATIENT'S NAME: ________________________________

*1. BP____________ WT____________ HT____________ VISION (R)____________(L)____________

*2. Cardiovascular Exam ____________ Normal ____________ Abnormal Comments:
Murmur ____________ Yes ____________ No Describe:

*3. Musculoskeletal Exam Record laxity, weakness, instability, decreased ROM-if abnormal

Knee ____________ Normal ____________ Abnormal
Ankle ____________ Normal ____________ Abnormal
Shoulder ____________ Normal ____________ Abnormal
Other Orthopedic ____________ Normal ____________ Abnormal
Problems, e.g. neck, feet, scoliosis)

4. Optional Exam – should be done if history is positive. Comments:

ENT ____________ Normal ____________ Abnormal
Chest ____________ Normal ____________ Abnormal
Abdomen ____________ Normal ____________ Abnormal
Genitalia ____________ Normal ____________ Abnormal
Skin ____________ Normal ____________ Abnormal

*ASSESSMENT: 5.A. ____________ No problems identified 5.B. Other:

*RECOMMENDATIONS:
6.A. ____ Unlimited B. ____ Limited to specific sports C. ____ Deferred until (e.g., rehab., recheck, consultation, lab, etc.)

*RE-EXAMINE: 7.A. ____ Yearly and after any injury that limits participation for greater than one week
B. ____ Other:

REQUIRED ELEMENTS ARE IN ASTERISK

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.

Are you licensed to practice medicine in the United States? _____ Yes _____ No

Signature ____ Phone Number ____________________________

Address ____ Date ____________________________________
____

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

(The following are considered disqualifying until medical and parental releases 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.)

IMPORTANT: THIS NOTIFICATION MUST BE SIGNED AND RETURNED BEFORE YOUR SON/DAUGHTER CAN PARTICIPATE IN THIS PROGRAM

TO: Parents of Students Participating in Athletics

DATE: ___________________________________

SUBJECT: STUDENT INSURANCE

SCHOOL: ___________________________________

SPORT: ___________________________________

The Union County Board of Education requires that the student insurance offered will be compulsory for all students participating in junior and senior high school athletics unless a notarized insurance waiver form is signed by the parent indicating adequate personal insurance and releasing the Board of Education and its employees from responsibility for any claim due to injuries received while participating in a school sponsored athletic program. Please be sure that you understand the following before deciding whether to permit your son or daughter to participate:

1. There are limitations in the Student Accident Insurance coverage. It will not always pay all charges for every accident. Read the description of the current Student Accident Insurance carefully and be sure that you understand it.

2. Neither the Board of Education nor any of its employees will assume responsibility for claims resulting from injury to your child while he/she is participating in this program. This means that you will have to pay for any necessary medical treatment not covered by the Student Accident Insurance or any personal insurance coverage that you might have.

In view of this Board policy and the current Student Accident Insurance coverage, I wish to proceed as follows (check one, sign, No. 3 must have notary signature, and return promptly):

1. ________ Enclosed please find $______________ for Student Accident Insurance. I understand that I am responsible for payment for any charges not covered by this policy.

2. ________ My son/daughter is already enrolled in the Student Accident Insurance Program, and I understand that I am responsible for payment of any charges not covered by this policy.

3. ________ I have adequate personal insurance and release the Board of Education and its employees from any responsibility in this matter.

SIGNED (Parent or Legal Guardian): ____

ADDRESS: ____

STUDENT'S FULL NAME ____

DATE: ____

(if Item No. 3 is checked, the following must be completed.)

I, ___________________________________, a Notary Public of _____________________ County and State of _________________ do certify that ____ personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal, this the ___________________ day of _______________________________, 20_________.

____
NOTARY PUBLIC

My Commission Expires: _________________________________

Each player must also receive a MEDICAL EXAMINATION by a physician licensed to practice medicine each calendar year (once every 365 days) in order to be eligible for practice or participation in interscholastic athletic contest. This verification **must** be in hands of Athletic Director prior to participation.