

## Sports Participation History Form

Form Currently Recommended by the NCMS Sports Medicine Committee

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	
			<b>1.</b> Has anyone in the athlete's family (grandmother, grandfather, mother, father, brother, sister) died suddenly before age 50?
			<b>2A.</b> Has the athlete ever stopped exercising because of dizziness or passed out during exercise?
			<b>2B.</b> Has the athlete ever been told he/she has a heart murmur or heart problem?
			<b>3.</b> Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?
			<b>4.</b> Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?
			<b>5.</b> Does the athlete have a history of a concussion (getting knocked out)?
			<b>6.</b> Has the athlete ever suffered a heat-related illness (heat stroke)?
			<b>7.</b> Does the athlete have anything he/she wants to talk about to the doctor?
			<b>8.</b> Does the athlete have a chronic illness or see a doctor regularly for any particular problem?
			<b>9.</b> Does the athlete take any medicine?
			<b>10.</b> Is the athlete allergic to any medications or bee stings?
			<b>11.</b> Does the athlete have only one of any paired organs (eyes, ears, kidneys, testicles, ovaries, etc.)?
			<b>12.</b> Does the athlete wear contacts or eye glasses?
			<b>13.</b> 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 or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

## Examination

Patient's Name: \_\_\_\_\_ BP \_\_\_\_\_

WT \_\_\_\_\_ (Minimal wt \_\_\_\_\_) HT \_\_\_\_\_ Vision (R) \_\_\_\_\_ (L) \_\_\_\_\_

### 2. Musculoskeletal Exam

	NORMAL	ABNORMAL	RECORD laxity, weakness, instability, decrease 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 greater than one 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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_