

Charlotte-Mecklenburg Schools Student-Athlete Pre-Participation Form

*** Please take the time, read through the questions, and answer to the best of your knowledge.***

PERSONAL INFORMATION

Name (First, MI, Last): _____ CMS Student ID # _____
 Gender: M F Date of Birth: _____ Age: _____ Home Phone: _____
 Parent(s) / Legal Guardian(s) Residing With: _____ Who has legal custody? _____
 Father's Name: _____ Phone (Work or Cellular): _____
 Mother's Name: _____ Phone (Work or Cellular): _____
 Street Address: _____ Apartment / Unit # _____
 City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT INFORMATION

Name (First, MI, Last): _____ Relationship: _____
 Street Address: _____ Apartment / Unit # _____
 City: _____ State: _____ Zip Code: _____
 Primary Phone: _____ Alternate Phone (Work or Cellular): _____
 Family Physician/Pediatrician: _____ Phone: _____
 Preferred Hospital: _____ Permission to Transport: Yes No

SPORT (*check all sports you are considering to participate in*)

| FALL | WINTER | SPRING |
|--|--|---|
| <input type="checkbox"/> Football | <input type="checkbox"/> Men Basketball | <input type="checkbox"/> Baseball |
| <input type="checkbox"/> Men Cross-Country | <input type="checkbox"/> Women Basketball | <input type="checkbox"/> Softball |
| <input type="checkbox"/> Men Soccer | <input type="checkbox"/> Wrestling | <input type="checkbox"/> Men Track |
| <input type="checkbox"/> Cheerleading | <input type="checkbox"/> Cheerleading | <input type="checkbox"/> Women Track |
| <input type="checkbox"/> Women Tennis | <input type="checkbox"/> Men Swimming / Diving | <input type="checkbox"/> Women Soccer |
| <input type="checkbox"/> Women Cross-Country | <input type="checkbox"/> Women Swimming / Diving | <input type="checkbox"/> Men Golf |
| <input type="checkbox"/> Women Volleyball | <input type="checkbox"/> | <input type="checkbox"/> Men Tennis |
| <input type="checkbox"/> Women Golf | <input type="checkbox"/> | <input type="checkbox"/> Men Lacrosse |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Women Lacrosse |

INSURANCE

School Board Policy (#5143) requires that all students who participate in athletics be adequately covered by medical or accident insurance. We certify that we have purchased and will maintain in full force and effect during student-athlete's participation in athletics the following insurance policy:

Check One: School Accident Insurance Personal Insurance Company

Name of Insurance Company _____ Policy Number _____ Group Number _____
 Insurance Phone for Authorization _____ Policy Holder _____

RELEASE

In consideration of CMS allowing the above-named individual to participate in athletics, we agree to release and hold CMS, its athletic coaches, and other employees free, harmless and indemnified from and against any and all claims, suits, or causes of action arising from or out of injury that the student-athlete may suffer from participation in athletics other than an injury from gross or willful negligence.

ASSUMPTION OF RISK

We acknowledge and understand that there is a risk of injury involved in athletic participation. We understand that the student-athlete will be under the supervision and the instructions of the coach in order to reduce the risk of injury to the student and other athletes. However, we acknowledge and understand that neither the coach nor CMS can eliminate the risk of injury in sports. Injuries may and do occur. *Sports injuries can be severe and in some cases may result in permanent disability or even death.* We freely, knowingly, and willfully accept and assume the risk of injury that might occur from participation in athletics.

PARENT / GUARDIAN SIGNATURE

Student-Athlete Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Name (First, MI, Last): _____ CMS Student ID # _____
 Gender: M F Date of Birth: _____ Age: _____ Home Phone: _____

HIPPA / FERPA RELEASE

The above named student-athlete has opted his/her rights under the US Department of Health and Human Resources guidelines. By signing this release, the student-athlete allows sharing of medical information between the Sports Medicine Staff (team physicians and medical staff, athletic trainers, and student assistants), the CMS Athletics Staff (Athletic Director and Coaches), CMS Administration and his/her medical provider(s). In the event of an emergency situation, information may be shared with emergency medical personnel. Every reasonable effort will be made to protect this information. It is understood that once this medical information is disclosed, it is no longer protected under the HIPAA/FERPA guidelines.

MEDICAL HISTORY

*** Please take the time, read through the questions, and answer to the best of your knowledge.***

The following questions should be answered by the student-athlete with the assistance of a parent/guardian. Explain any "Yes" answers below. If additional space is needed, please attach to this form.

| <u>General Medical History</u> | YES | NO |
|--|--------------------------|--------------------------|
| 1. Does the athlete have a chronic illness or see a doctor regularly for any particular problem? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has the athlete had surgery other than a tonsillectomy? --- | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has the athlete ever been hospitalized? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does the athlete have sickle cell trait? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does the athlete have history of seizures? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have any skin problems other than acne? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has the athlete ever suffered a heat-related illness (heat exhaustion or heat stroke)?----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had a head injury, been knocked out, lost your memory, had your 'bell rung', or concussion?--- | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had mononucleosis or any significant illness in the last 60 days? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you wear glasses or contacts? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does the athlete have trouble with hearing or wear hearing aid(s)? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the-counter)? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever taken any supplements or vitamins to help with weight loss/gain or improve performance? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have any allergies (seasonal, insects, food, or medicines)? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you want to weigh more or less than you do now? --- | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do you lose weight regularly to meet weight requirements for you sport or other reasons? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you feel stressed out, tired, or depressed? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever been denied or restricted from participation in sports? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Are there any other issues you would like to discuss with a healthcare professional? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| FEMALES ONLY | | |
| 21. Are your periods regular (every month)? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Are your periods heavy? ----- | <input type="checkbox"/> | <input type="checkbox"/> |

| <u>Cardiovascular History</u> | YES | NO |
|---|--------------------------|--------------------------|
| 1. Do you cough, wheeze or have extreme trouble breathing with exercise? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you use an inhaler? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever passed out/nearly passed out during/ after exercise? <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever been dizzy during or after exercise? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Ever had chest pain/discomfort during or after exercise? -- | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you tire more easily or more quickly than your friends during exercise? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever had a racing of your heart or skipped heartbeats? --- | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Ever been told you had a heart murmur? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever been told you have high blood pressure? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has any member of your family: | | |
| • Died of heart problems or sudden death before age 50? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| • Been told they had a serious heart problem before age 50? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| • Been told they had Marfan's syndrome? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| • Hypertrophic or dilated cardiomyopathy? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| • Heart rhythm abnormality? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| Orthopedic History | | |
| 1. Has the athlete ever broken or fractured any bones? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has the athlete ever subluxed or dislocated any joint? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a stinger, burner, or pinched nerve? --- | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any other problems related to your: | | |
| • Neck, spine, or back? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| • Shoulders? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| • Elbows? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| • Wrists, hands, fingers? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| • Hips? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| • Knees? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| • Ankles, feet, or toes? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| • Other? ----- | <input type="checkbox"/> | <input type="checkbox"/> |

Please explain "Yes" answers in the space below. Please put date(s) of any injuries along with explanation: _____

CERTIFICATION / MEDICAL AUTHORIZATION

We certify that all of the information provided by us on this form is correct. We agree by the rules of the NCHSAA and CMS. We give our consent for the student-athlete to receive a medical screening prior to participation in athletics and **acknowledge that this is simply a screening evaluation and not suitable for regular health care**. If the student-athlete is injured while participating in athletics and CMS is unable to contact the parent, we grant CMS permission and the authority to obtain necessary medical care and/or treatment for the student's injury including first aid, CPR, medical or surgical treatment recommended by a physician and we accept the financial responsibility for such medical care or treatment.

PARENT / GUARDIAN SIGNATURE

Student-Athlete Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Name (First, MI, Last): _____ CMS Student ID # _____

PHYSICAL EXAMINATION: To be completed by a Physician, Physician's Assistant, or Nurse Practitioner ONLY

Height: _____ Weight: _____ Pulse: _____ Blood Pressure (sitting): (arm) _____ (leg) _____
 Vision: Right 20 / _____ Left 20 / _____ Corrected: Y N Body Fat% (opt.): _____ UA (opt.): _____

| | Normal | Abnormal Findings | Initials |
|--|--------|-------------------|----------|
| General Medical | | | |
| Appearance/Emotional Affect | | | |
| Head/Eyes/Ears/Nose/Throat | | | |
| Lymph Nodes | | | |
| Heart (standing/supine) | | | |
| Pulses (include femoral) | | | |
| Lungs | | | |
| Abdomen (include liver, spleen) | | | |
| Skin | | | |
| Neurologic (Balance, Coordination) | | | |
| Genitalia (males only) | | | |
| Orthopedic Record if any laxity, weakness, instability, decreased ROM | | | |
| Cervical/Spine | | | |
| Shoulder/Arm | | | |
| Elbow/Forearm | | | |
| Wrist/Hand | | | |
| Hip/Thigh | | | |
| Knee | | | |
| Leg/Ankle | | | |
| Foot | | | |
| Cardiologic (optional) | | | |
| EKG | | | |
| Echocardiogram | | | |
| Neurologic (optional) | | | |
| Baseline Neuropsychologic Testing | | | |

CLEARANCE

I, the undersigned, certify that I have examined this student-athlete and find him/her medically:

- Cleared**
 Deferred until: (e.g. Rehab, consultation, lab, referral, etc.) _____
 May participate in the following sport(s) ONLY: (CHECK ALL THAT APPLY)
 _____ Contact/Collision _____ Limited Contact _____ Non-Contact/Strenuous _____ Non-Contact/Non-Strenuous

| Classification of Sports by Contact | | | |
|--|-----------------------|---------------------------|----------------------|
| Contact/Collision | Limited Contact | Non-Contact | |
| | | <u>Strenuous</u> | <u>Non-Strenuous</u> |
| Football | Baseball/Softball | Discus, Javelin, Shot Put | Golf |
| Wrestling | Basketball | Running/Cross Country | |
| Lacrosse | Cheerleading | Swimming | |
| | Diving | Tennis | |
| | High Jump, Pole Vault | Strength Training | |
| | Volleyball | | |

Please specify each condition requiring clearance before participating in a sport in the classification checked above:

Not cleared

Due to: _____

The following are considered disqualifying, but not limited to, until medical and parental releases are obtained: Atlantoaxial instability; Bleeding disorder; Hypertension; Dysrhythmia; Mitral valve prolapse; Acute infections; Obvious growth retardation; Diabetes mellitus; Jaundice; Severe visual or auditory impairment; Pulmonary insufficiency; Organ transplant recipient; Enlarged liver or spleen; Hernia; Musculoskeletal deformity associated with functional loss; History of convulsions or repeated concussions; Absence of one kidney, eye, testicle, ovary, etc.

Physician's Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____

Signature: _____

Physician's/Provider's Stamp

MD DO PA NP

Date: _____