Section I must be COMPLETED & SIGNED by parent or guardian before physical is administered. Completed forms must be turned in online before conditioning or tryouts begin. Incomplete forms will result in the student being denied participation to try out, practice and/or compete.

2019-20 ATHLETIC PHYSICAL/AUTHORIZATION FORM

Student's Last _____ First _____ Middle _____ 2019-20 Grade _____ Sport(s) played _____

Address _____ Home Phone _____ Date of Birth _____ Age _____ Male Female (circle one)

Father _____ Work # _____ Cell # _____

Mother _____ Work # _____ Cell # _____

Emergency Contact/Contact # (if parents/guardian cannot be reached) _____

I. HEALTH QUESTIONS (To be completed by parent or guardian.)

If answered yes to any of the questions below please elaborate on the back of this form.

____ Yes ____ No Does the athlete have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, etc.]?
List: _____

____ Yes ____ No Is the athlete presently taking any medications or pills? _____

____ Yes ____ No Does the athlete have any allergies (medicine, bees or other stinging insects, latex)?

____ Yes ____ No Does the athlete have the sickle cell trait?

____ Yes ____ No Has the athlete ever had a head injury, been knocked out, or had a concussion? Date: _____

____ Yes ____ No Has the athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?

____ Yes ____ No Has the athlete ever passed out or nearly passed out DURING exercise, emotion or startle?

____ Yes ____ No Has the athlete ever fainted or passed out AFTER exercise?

____ Yes ____ No Has the athlete had extreme fatigue (been really tired) with exercise (different from other children)?

____ Yes ____ No Has the athlete ever had trouble breathing during exercise, or a cough with exercise?

____ Yes ____ No Has the athlete ever been diagnosed with exercise-induced asthma ?

____ Yes ____ No Has a doctor ever told the athlete that they have high blood pressure?

____ Yes ____ No Has a doctor ever told the athlete that they have a heart infection?

____ Yes ____ No Has a doctor ever ordered an EKG, ECG, Echo Cardiogram or other test for the athlete's heart, or has the athlete ever been told they have a murmur?

____ Yes ____ No Has the athlete ever had discomfort, pain, or pressure in his/her chest during or after exercise or complained of their heart "racing" or "skipping beats"?

____ Yes ____ No Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?

____ Yes ____ No Has the athlete ever had a stinger, burner or pinched nerve?

____ Yes ____ No Has the athlete ever had any problems with their eyes or vision?

____ Yes ____ No Has the athlete ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints?

__ Head __ Shoulder __ Thigh __ Neck __ Elbow __ Knee __ Chest __ Hip
__ Forearm __ Shin/calf __ Back __ Wrist __ Ankle __ Hand __ Foot

____ Yes ____ No Has the athlete ever had an eating disorder, or do you have any concerns about their eating habits or weight?

____ Yes ____ No Has the athlete ever been hospitalized or had surgery?

____ Yes ____ No Has the athlete had a medical problem or injury since their last evaluation?

____ Yes ____ No Has the athlete had/been: 1. Little interest or pleasure in doing things; 2. Feeling down, depressed, or hopeless for more than 2 weeks in a row; 3. Feeling bad about himself/herself that they are a failure, or let their family down; 4. Thoughts that he/she would be better off dead or hurting themselves?

FAMILY HISTORY

____ Yes ____ No Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?

____ Yes ____ No Has any family member had unexplained heart attacks, fainting or seizures?

____ Yes ____ No Does the athlete have a father, mother or brother with sickle cell disease?

Parent's Signature _____ Date _____

Student's Name _____ Date of Birth _____

II. PHYSICAL BY A LICENSED NC MEDICAL DOCTOR

BP _____
Pulse _____
Height _____
Weight _____
Skin _____
Eyes/Mouth _____
Chest - Heart - Murmurs - Rhythm _____
Lungs _____
Spine _____

Upper Ext. Left _____
Upper Ext. Right _____
Lower Ext. Left _____
Upper Ext. Right _____

Vision
R 20/_____
L 20/_____
Corrected:
___ Yes ___ No

OPTIONAL
HEENT _____
Abdominal Exam _____
Genitalia (Males) _____
Hernia (Males) _____

III. PHYSICAL BY A LICENSED NC MEDICAL DOCTOR

CLEARANCE FOR PRACTICES/GAMES:

___ Cleared

___ Cleared after completing evaluation/rehabilitation for: _____

___ ***Medical Waiver Form (must be attached) for the condition of: _____

___ Not cleared for: ___ Collision ___ Contact ___ Non-contact ___Strenuous ___ Moderately strenuous ___ Non-strenuous

Due to: _____

Physician Notes: _____

Additional Recommendations/Rehab Instructions: _____

Physician's Name (Please Print) _____

Physician's Signature and circling of designated degree REQUIRED MD DO PA NP

Physical expires 13 months from DATE OF EXAM.

Date of Exam: _____
Provider Address: _____
_____
Provider Phone: _____

PLEASE STAMP PHYSICIAN'S NAME/ADDRESS/PHONE
Physical must be completed each year.

***The following are considered disqualifying until appropriate medical parental release 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 musculosketal 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 consistent with and contains the necessary information for scholastic sports physical as described by the North Carolina High School Athletic Association Sports Medicine Advisory Committee.