NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION
SPORT PREPARTICIPATION EXAMINATION FORM

Patient's Name: _____ **Age:** _____

This is a screening examination for participation in sports. This does not substitute for a comprehensive examination with your child's regular physician where important preventive health information can be covered.

Athlete's Directions: Please review all questions with your parent or legal custodian and answer them to the best of your knowledge.
Parent's Directions: Please assure that all questions are answered to the best of your knowledge. Not disclosing accurate information may put your child at risk during sports activity.
Physician's Directions: We recommend carefully reviewing these questions and clarifying any positive answers.

Explain "Yes" answers below	Yes	No	Don't know
1. Has the athlete ever been hospitalized or had surgery?	❑	❑	❑
2. Is the athlete presently taking any medications or pills?	❑	❑	❑
3. Does the athlete have any allergies (medicine, bees or other stinging insects, latex)?	❑	❑	❑
4. Has the athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	❑	❑	❑
5. Has the athlete ever fainted or passed out AFTER exercise?	❑	❑	❑
6. Has the athlete had extreme fatigue associated with exercise (different from other children)?	❑	❑	❑
7. Has the athlete ever had trouble breathing during exercise, or a cough with exercise?	❑	❑	❑
8. Has the athlete ever been diagnosed with exercise-induced asthma?	❑	❑	❑
9. Has a doctor ever told the athlete that they have high blood pressure?	❑	❑	❑
10. Has a doctor ever told the athlete that they have a heart infection?	❑	❑	❑
11. Has a doctor ever ordered an EKG or other test for the athlete's heart, or has the athlete ever been told they have a murmur?	❑	❑	❑
12. Has the athlete ever had discomfort, pain, or pressure in his chest during or after exercise or complained of their heart "racing" or "skipping beats"?	❑	❑	❑
13. Has the athlete ever had a head injury, been knocked out, or had a concussion?	❑	❑	❑
14. Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	❑	❑	❑
15. Has the athlete ever had a stinger, burner or pinched nerve?	❑	❑	❑
16. Has the athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	❑	❑	❑
17. Has the athlete ever had any problems with their eyes or vision?	❑	❑	❑
18. 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			
19. Has the athlete ever had an eating disorder, or do you have any concerns about your eating habits or weight?	❑	❑	❑
20. Does the athlete have any chronic medical illnesses (diabetes, asthma, kidney problems, etc.)?	❑	❑	❑
21. Has the athlete had a medical problem or injury since their last evaluation?	❑	❑	❑
22. Does the athlete have the sickle cell trait?	❑	❑	❑
FAMILY HISTORY	❑	❑	❑
23. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?	❑	❑	❑
24. Has any family member had unexplained heart attacks, fainting or seizures?	❑	❑	❑
25. Does the athlete have a father, mother or brother with sickle cell disease?	❑	❑	❑

Elaborate on any positive (yes) answers: _____

_____

_____

_____

I have reviewed and answered each question above, and assure that all are accurate responses. Furthermore, I give permission for my child to participate in sports.

Signature of parent/legal custodian: _____ Date: _____

Signature of Athlete: _____ Date: _____ Phone #: _____

Physical Examination (Must be Completed by a Licensed Physician, Nurse Practitioner or Physician's Assistant)

Athlete's Name_____ Age_____ Date of Birth _____

Height_____ Weight_____ BP _____(% ile) / _____(% ile) Pulse____

Vision R 20/_____ L 20/_____ Corrected: Y N

These are required elements for all examinations			
	NORMAL	ABNORMAL	ABNORMAL FINDINGS
PULSES			
HEART			
LUNGS			
SKIN			
NECK/BACK			
SHOULDER			
KNEE			
ANKLE/FOOT			
Other Orthopedic Problems			

Optional Examination Elements – Should be done if history indicates

HEENT			
ABDOMINAL			
GENITALIA (MALES)			
HERNIA (MALES)			

Clearance**:

☐ A. Cleared

☐ B. Cleared after completing evaluation/rehabilitation for :_____

☐ C. Not cleared for: ☐ Collision ☐ Contact

☐ Non-contact _____Strenuous _____Moderately strenuous _____Non-strenuous

Due to:_____

Additional Recommendations/Rehab Instructions:_____

Name of Physician/Extender: Leamor Buenaseda, MD, FAAP

Signature of Physician/Extender_____ MD DO PA NP

(Signature and circle of designated degree required)

Date of exam:_____

Address: 4005 Fayetteville Road, Raeford, NC, 38376

Phone 910-848-5437

Physician Office Stamp:

Leamor Buenaseda, MD, FAAP - Kids First Pediatrics of Raeford
4005 Fayetteville Road,Raeford, NC, 38376
Ph: 910-848-5437, Fax: 910-848-5439

(** The following are considered disqualifying until appropriate medical and parental releases are obtained: post-operative clearance, acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, a chronic musculoskeletal condition that limits ability for safe exercise/sport (i.e. Klippel-Feil anomaly, Sprengel's deformity), history of convulsions or concussions, absence of/ or one kidney, eye, testicle or ovary, etc.)

This form approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee December 2009, and the NCHSAA Board of Directors reviewed annually.