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.

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

FEMALES ONLY	YES	NO
21. Are your periods irregular (not every month)?	☐	☐
22. Are your periods heavy?	☐	☐

Cardiovascular History	YES	NO
1. Do you cough, wheeze or have extreme trouble breathing with exercise?	☐	☐
2. Do you use an inhaler?	☐	☐
3. Ever passed out/nearly passed out during/after exercise?	☐	☐
4. Ever been dizzy during or after exercise?	☐	☐
5. Ever had chest pain/discomfort during or after exercise?	☐	☐
6. Do you tire more easily or more quickly than your friends during exercise?	☐	☐
7. Ever had a racing of your heart or skipped heartbeats?	☐	☐
8. Ever been told you had a heart murmur?	☐	☐
9. Ever been told you have high blood pressure?	☐	☐
10. Has any member of your family:		
• Died of heart problems or sudden death before age 50?	☐	☐
• Been told they had a serious heart problem before age 50?	☐	☐
• Been told they had Marfan's syndrome?	☐	☐
Hypertrophic or dilated cardiomyopathy?	☐	☐
Heart rhythm abnormality?	☐	☐

Orthopedic History	YES	NO
1. Has the athlete ever broken or fractured any bones?	☐	☐
2. Has the athlete ever subluxed or dislocated any joint?	☐	☐
3. Have you ever had a stinger, burner, or pinched nerve?	☐	☐
4. Have you had any other problems related to your:		
• Neck, spine, or back?	☐	☐
• Shoulders?	☐	☐
• Elbows?	☐	☐
• Wrists, hands, fingers?	☐	☐
• Hips?	☐	☐
• Knees?	☐	☐
• Ankles, feet, or toes?	☐	☐
• Other?	☐	☐

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 NCDPI 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.

We (student and parents) certify that the home address shown in this document is the student's sole bona fide residence, and we will notify the school principal immediately of any change in residence, since such a move may alter the eligibility status of the student athlete.
All information contained in this form is accurate and correct.

Student-Athlete: ________________________ **Date:** ____________
(Signature)

Parent/Guardian: ________________________ **Date:** ____________
(Please Print Name)

Parent/Guardian: ________________________ **Date:** ____________
(Signature)

Page 3 of this document must be completed by a Physician, Physician's Assistant or Nurse Practitioner

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 Neuropsychological 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**	
		Strenuous	***Non-Strenuous***
☐ Football	☐ Baseball/Softball	☐ Discus, Javelin, Shot Put	☐Golf
☐ Soccer	☐ Basketball	☐ Running/Cross Country	
	☐ Cheerleading	☐ Swimming	
	☐ Volleyball	☐ Tennis	
	☐ High Jump, Pole Vault	☐ Strength Training	

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: ______________________________

Address: ______________________________

____

Phone: ______________________________

Physician Office Stamp:

Signature ______________________________ MD PA NP

Date of exam: ____________________