

New Hanover County Schools

Pre-participation Sports Screening

History

This page to be completed by student and parent/guardian.

Name: _____ Sex: _____ Age: _____ Date of Birth: _____
Students Name

Grade: _____ School: _____ Sports: _____

Address: _____ Phone: _____

Personal Physician: _____

In Case of "Emergency, Contact

Name: _____ Relationship: _____

Phone (Home): _____ (Work): _____ (Cell): _____

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has anyone in the athlete's family (parents, grandparents) died suddenly before the age of 50 years? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Has the athlete ever passed out during exercise or stopped exercise because of shortness of breath, chest pain, palpitations, heart murmur or have a history of rheumatic fever? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Does the athlete have asthma (wheezing) hay fever, or coughing spells during exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Does the athlete have a history of a concussion (getting knocked out) or have seizures? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Has the athlete ever broken a bone, had a joint injury, had to wear a cast, had any surgeries or spent the night in a hospital? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Does the athlete have a chronic illness or see a physician regularly for any particular reason? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Does the athlete take any medications, herbs or supplements? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Is the athlete allergic to any medications, foods or bee stings? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Does the athlete have only one of any paired organs (eyes, ears, kidneys, testicles, ovaries, etc?) |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Does the athlete wear contact lenses, glasses or braces? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Has the athlete ever had prior limitation from sports participation? |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Does the athlete have anything he or she wants to discuss with the physician? |

Explain any yes answers:

Date of last tetanus immunization (Td, Tdap): _____ (Attach athlete's immunization record if possible)

Important Note:

1. A Tdap (tetanus, diphtheria, pertussis) vaccine is now **required** for all students entering 6th grade. If more than 5 years have passed since the last dose the student will be required to have this vaccine.
2. All teens **need** a Tdap vaccination if more than 5 years have passed since last dose.

If you would like the athlete to receive a Tdap during the Sports Screening initial here: _____

Print parent/guardian name

Signature of parent/guardian

Date

New Hanover County Schools

Pre-participation Sports Screening

Name: _____ Date of Birth: _____
Students Name

School: _____ Height: _____ Weight: _____

BP: _____ / _____ Pulse: _____ Vision R 20/ _____ L 20/ _____

Physical Examination

Normal

Abnormal

- | | | | |
|--------------------------|---------------------------------|--------------------------|-------|
| <input type="checkbox"/> | 1. Chest | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 2. Lungs | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 3. Heart | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 4. Abdomen | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 5. Neurologic | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 6. Spine, Back | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 7. Shoulders, Upper extremities | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> | 8. Lower extremities | <input type="checkbox"/> | _____ |

Assessment: Full participation
 Limited participation (describe limitations, restrictions): _____

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed Medical Doctor, Physician's Assistant, or Family Nurse Practitioner in the United States.

Date of Exam: _____

Signature: _____ Phone #: _____

Address: _____

If athlete not qualified, REFER FOR FURTHER EVALUATION TO: _____
