Charlotte-Mecklenburg Schools

Middle School Student-Athlete Pre-Participation Form

TAB THROUGH FORM & TYPE INFORMATION OR PRINT FORM AND WRITE INFORMATION

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| PERSONAL & EMERGENCY CONTACT INFORMATION |
| Student-Athlete’s Name (First, MI, Last):  |       | CMS Student ID # |       |  |
| Gender: [ ]  M [ ]  F  | Date of Birth:  |       | Age: |       | Home Phone:  |       |  |
| Resides At Street Address:  |       | City: |       | State: |    | Zip Code: |       | County: |       |  |
|  |  |  |  |  |  |  |
| Father’s Name: |       | Daytime Phone: |       |  Cell Phone: |       |  |
| Street Address:  |       | City: |       | State: |    | Zip Code: |       | County: |       |  |
|  |  |  |  |  |  |  |
| Mother’s Name: |       | Daytime Phone: |       |  Cell Phone: |       |  |
| Street Address:  |       | City: |       | State: |    | Zip Code: |       | County: |       |  |
|  |  |  |  |  |  |  |
| *If applicable…* Guardian’s Name: |       | Daytime Phone: |       |  Cell Phone: |       |  |
| Street Address:  |       | City: |       | State: |    | Zip Code: |       | County: |       |  |
| • If student-athlete resides with other than parent(s), attach legal documentation of custody (guardianship or affidavit provided by Student Placement)Failure to provide accurate and up-to-date residence information may be grounds for loss of athletic eligibility |

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| SPORT (check all sports you are considering to participate in) |
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| Fall | Winter | Spring |
|  [ ]  Cheerleading |  [ ]  Basketball - Boy’s |  [ ]  Baseball |
|  [ ]  Football |  [ ]  Basketball - Girl's |  [ ]  Soccer - Boy's |
|  [ ]  Golf - Boy's |  [ ]  Cheerleading |  [ ]  Soccer - Girl's |
|  [ ]  Golf - Girl's |  |  [ ]  Track - Boy's |
|  [ ]  Softball |  |  [ ]  Track - Girl's |
|  [ ]  Volleyball - Girl's |  |  |

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| INSURANCE |
| School Board Policy JLA requires that all students who participate in athletics be adequately covered by medical or accident insurance. We acknowledge that it is the signed responsibility to notify CMS of any changes that occur to the personal insurance policy below and affect the procedures in which the above-named individual may receive treatment; this includes loss of coverage. 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 |  |  |

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| 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.  |

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| 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-athlete 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. |

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| HIPAA / 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.  |

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| SEVENTH GRADE ENTRY |
| • This is my |       | consecutive semester at |       | Middle School |
| • I initially entered the seventh grade in the fall of (yr.) |      |  |
| • Last semester I attended |       | School in City |       | State |    |  |
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Parent/Guardian Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student-Athlete Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 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 | *Cardiovascular History*  | YES | NO |
| 1. Does the athlete have a chronic illness or see a doctor regularly for any particular problem? -------------------------------------------------------------------------- | [ ]  | [ ]  | 1. Do you cough, wheeze or have extreme trouble breathing with exercise? ------- | [ ]  | [ ]  |
| 2. Has the athlete had surgery other than a tonsillectomy? --------------------------- | [ ]  | [ ]  | 2. Do you use an inhaler? ------------------------------------------------------------------------ | [ ]  | [ ]  |
| 3. Has the athlete ever been hospitalized? ----------------------------------------------- | [ ]  | [ ]  | 3. Ever passed out/nearly passed out during/after exercise? --------------------------- | [ ]  | [ ]  |
| 4. Does the athlete have sickle cell trait? -------------------------------------------------- | [ ]  | [ ]  | 4. Ever been dizzy during or after exercise? ------------------------------------------------ | [ ]  | [ ]  |
| 5. Does the athlete have history of seizures? -------------------------------------------- | [ ]  | [ ]  | 5. Ever had chest pain/discomfort during or after exercise? ---------------------------- | [ ]  | [ ]  |
| 6. Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)? -------------------------------------------------------------------- | [ ]  | [ ]  | 6. Do you tire more easily or more quickly than your friends during exercise? ----- | [ ]  | [ ]  |
| 7. Do you have any skin problems other than acne? ----------------------------------- | [ ]  | [ ]  | 7. Ever had a racing of your heart or skipped heartbeats? ------------------------------ | [ ]  | [ ]  |
| 8. Has the athlete ever suffered a heat-related illness (heat exhaustion or heat stroke)? ---------------------------------------------------------------------------------------- | [ ]  | [ ]  | 8. Ever been told you had a heart murmur? ------------------------------------------------ | [ ]  | [ ]  |
| 9. Have you ever had a head injury, been knocked out, lost your memory, had your ‘bell rung’, or concussion? ---------------------------------------------------------- | [ ]  | [ ]  | 9. Ever been told you have high blood pressure? ----------------------------------------- | [ ]  | [ ]  |
| 10. Have you had mononucleosis or any significant illness in the last 60 days?-- | [ ]  | [ ]  | 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? ------------------------------------------------ | [ ] [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ] [ ]  |
| 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? ---------------------------------------------------- | [ ]  | [ ]  | *Orthopedic History* | YES | NO |
| 15. Do you have any allergies (seasonal/insects/food/medicines)? ---------------- | [ ]  | [ ]  | 1. Has the athlete ever broken or fractured any bones? --------------------------------- | [ ]  | [ ]  |
| 16. Do you want to weigh more or less than you do now? ---------------------------- | [ ]  | [ ]  | 2. Has the athlete ever subluxed or dislocated any joint? ------------------------------- | [ ]  | [ ]  |
| 17. Do you lose weight regularly to meet weight requirements for you sport or other reasons? ------------------------------------------------------------------------------ | [ ]  | [ ]  | 3. Have you ever had a stinger, burner, or pinched nerve? ---------------------------- | [ ]  | [ ]  |
| 18. Do you feel stressed out, tired, or depressed? -------------------------------------- | [ ]  | [ ]  | 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? --------------------------------------------------------------------------------------- | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  |
| 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? ------------------------------------------------------------------ | [ ]  | [ ]  |

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

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| 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)* |
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Physician, Physician’s Assistant or Nurse Practitioner

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

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| 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 |  |  |  |

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| 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

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| *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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| *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.* |

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| Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Physician Office Stamp: |
| Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MD PA NP | Date of exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |