

ATHLETE'S FULL NAME _____

Date of Birth: _____

Dear Parent/Guardian:

The pre-participation examination (copy attached) is a limited medical checkup to screen your child to see if he/she can safely participate in sports. The examination does screen for the common problems that have been shown to be a danger to athletes. It is not a comprehensive medical examination and often does not detect rare medical conditions. If you have concerns about your child having a serious medical illness, please schedule a visit with our physical physician. Additionally, your child's regular health care, routine physical examinations, and laboratory testing should continue to come from his/her personal physician.

.....

I recognize that there are inherent risks in all athletic events (head and spinal cord injuries, fractures, etc.), and hereby give my permission to Mattamuskeet Early College High School for my son/daughter to participate in interscholastic athletic activities.

Permission is hereby granted to Mattamuskeet Early College High School and its authorized representatives to proceed with any needed medical or minor surgical treatment, X-ray examination, and immunization for the above named individual. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious manner possible. If said physician is unable to communicate with me, the treatment necessary for the best interest of the above named individual may be given.

I hereby release Mattamuskeet Early College High School and members of its athletic staff including, but not limited to, its coaches, trainers, administrators, and all others connected with school athletic activities from any and all damages for injuries sustained by my son/daughter while participating in any sports activity connected with Mattamuskeet Early College High School and do hereby agree to hold harmless any and all of the above from any and all damages which they may suffer as a result sustained by my son/daughter while participating as above stated.

Is above names student allergic to any medication? ___ Yes ___ No

If yes, list medication(s): _____

Emergency contact if Parent/Guardian not available:

Name: _____ **Phone:** _____

Physician's Name: _____ **Phone:** _____

Signature of Parent/Guardian: _____ **Date:** _____

Home Phone: _____ **Business Phone:** _____

MATTAMUSKEET SCHOOL ATHLETIC PARTICIPATION RELEASE FORM

Please read carefully and fill out completely.

If any information changes, notify Mattamuskeet Early College High School immediately.

STUDENT'S NAME: _____ **DATE OF BIRTH:** _____

ACADEMIC YEAR: _____ **CURRENT GRADE (CIRCLE):** 6 7 8 9 10 11 12 13

SPORT(S): INDICATE ON LIST

___ Football ___ Volleyball ___ Cross Country ___ Basketball ___ Track ___ Baseball ___ Softball ___ Trainer ___ Manager
___ Cheerleader

I recognize that there are inherent risks in all athletic events (head and spinal cord injuries, fractures, etc.) and hereby give my permission to Mattamuskeet Early College High School for my son/daughter to participate in interscholastic athletic activities.

Permission is hereby granted to Mattamuskeet Early College High School and its authorized representatives to proceed with any needed medical or minor surgical treatment, x-ray examination, and immunization for the above named individual in the event of serious illness, the need for major surgery, or significant accidental injury. I understand that an attempt will be made by the attending physician to contact me in the most expeditious manner possible. If said physician is unable to communicate with me, the treatment necessary for the best interest of the above name individual may be given.

I hereby release Mattamuskeet Early College High School and members of its athletic staff including, but not limited to, its coaches, trainers, administrators, and all others connected with school athletic activities, from any and all damages for injuries sustained by my son/daughter while participating in any sports activity connected with the Hyde County Schools, and do hereby agree to indemnify and hold harmless any and all of the above from any and all damages which they may suffer as a result of injuries sustained by my son/daughter while participating as above stated.

Is student named above allergic to any medication? Yes ___ No ___ If yes, list medications: _____

INSURANCE STATEMENT

STATEMENT OF INSURANCE COVERAGE

_____ (Student/Athlete) of Mattamuskeet Early College High School is adequately covered by family/personal accident / medical insurance with the _____ Insurance Company, Policy No. _____. Hyde County Schools will provide catastrophic scholastic student accident coverage for athletics. All high school Football Players are required to purchase School Insurance. Neither the athletic staff of Mattamuskeet Early College High School nor the Administration of Mattamuskeet Early College High School, nor Hyde County Schools will be responsible for any claim due to and injury received by the above named student while he/she is participating in the athletic program at Mattamuskeet School. No medical bills will be paid by Mattamuskeet Early College High School. Indicate below whether fathers' or mothers' insurance applies.

Father's Name
Employer: _____

Mother's Name
Employer: _____

The address below is the legal residence for my son/daughter while attending Mattamuskeet Early College High School. My signature indicates that I have read and understand the above information and that the information submitted is to my knowledge correct and accurate.

Signature of Parent/Guardian (Required) Relationship to Student Date

I have read this participation form and the signature above is that of my parent/guardian.

Signature of Student (Required) Date

Legal Residence: _____ Zip: _____ Home Phone: _____

Business Phone: _____

Next of Kin: _____ Relationship: _____ Phone: _____

Family Physician: _____ Orthopedic Surgeon: _____

Hospital _____

..... Non-prescription Medication Authorization

I further consent to the faculty trainer and/or team physician, in the exercise of their discretion, providing various non-prescription legal medications to my son/daughter for the relief of minor athletic and non-athletic problems. The use of such medication shall be entirely at the option of my son/daughter. I do hereby release Mattamuskeet Early College High School and the members of its athletic staff, including, but not limited to, its coaches, trainers, administrators, team physicians, and all others connected with school athletic activities from any and all damages for injuries or illnesses occurring from taking such non-prescription medications. The execution of this non-prescription medication authorization consent is in no manner a prerequisite or condition to my son/daughter being eligible to participate in the program.

Signature of Parent/Guardian Relationship to Student Date

NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION SPORT PREPARTICIPATION EXAMINATION FORM

Patient's Name: _____ Age: _____ Sex: _____

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. If you do not understand or don't know the answer to a question please ask your doctor. 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 or Don't Know answers.

Explain "Yes" answers below	Yes	No	Don't know
1. Does the athlete have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, etc.]? List: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the athlete presently taking any medications or pills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the athlete have any allergies (medicine, bees or other stinging insects, latex)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the athlete have the sickle cell trait?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the athlete ever had a head injury, been knocked out, or had a concussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the athlete ever fainted or passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the athlete had extreme fatigue (been really tired) with exercise (different from other children)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has the athlete ever had trouble breathing during exercise, or a cough with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the athlete ever been diagnosed with exercise-induced asthma ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has a doctor ever told the athlete that they have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has a doctor ever told the athlete that they have a heart infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. 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"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Has the athlete ever had a stinger, burner or pinched nerve?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Has the athlete ever had any problems with their eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Has the athlete ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints? <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Chest <input type="checkbox"/> Hip <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Hand <input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Has the athlete ever had an eating disorder, or do you have any concerns about your eating habits or weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Has the athlete ever been hospitalized or had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Has the athlete had a medical problem or injury since their last evaluation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FAMILY HISTORY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Has any family member had unexplained heart attacks, fainting or seizures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Does the athlete have a father, mother or brother with sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Elaborate on any positive (yes) answers: _____

If additional space is needed attach a separate sheet

By signing below I agree that I have reviewed and answered each question above. Every question is answered completely and is correct to the best of my knowledge. Furthermore, as parent or legal custodian, I give consent for this examination and give permission for my child to participate in sports.

Signature of parent/legal custodian: _____ Date: _____

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

Athlete's Name _____ Age _____ Date of Birth _____

Height _____ Weight _____ BP _____ (_____ % ile) / _____ (_____ % ile) Pulse _____

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

Physical Examination (Below Must be Completed by Licensed Physician, Nurse Practitioner or Physician Assistant)

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. Medical Waiver Form must be attached (for the condition of: _____)
- D. Not cleared for: Collision Contact
- Non-contact _____ Strenuous _____ Moderately strenuous _____ Non-strenuous

Due to: _____

Additional Recommendations/Rehab Instructions: _____

Name of Physician/Extender: _____

Signature of Physician/Extender _____ MD DO PA NP

(Signature and circle of designated degree required)

Date of exam: _____

Address: _____

Phone _____

<p>Physician Office Stamp:</p>

(*** The following are considered disqualifying until appropriate medical and parental releases 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 musculoskeletal 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 approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee and the NCHSAA Board of Directors.
This form is current as of April 2016