

Charlotte-Mecklenburg Schools
Middle School Student-Athlete Pre-Participation Form

*** Please take the time, read through the questions, and answer to the best of your knowledge.***

PERSONAL INFORMATION

Name (First, MI, Last): _____ CMS Student ID # _____
Gender: ☐ M ☐ F Date of Birth: _____ Age: _____ Home Phone: _____
Parent(s) / Legal Guardian(s) Residing With: _____ Who has legal custody? _____
Father's Name: _____ Phone (Work or Cellular): _____
Mother's Name: _____ Phone (Work or Cellular): _____
Street Address: _____ Apartment / Unit # _____
City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT INFORMATION

Name (First, MI, Last): _____ Relationship: _____
Street Address: _____ Apartment / Unit # _____
City: _____ State: _____ Zip Code: _____
Primary Phone: _____ Alternate Phone (Work or Cellular): _____
Family Physician/Pediatrician: _____ Phone: _____
Preferred Hospital: _____ Permission to Transport: ☐ Yes ☐ No

SPORT (*check all sports you are considering to participate in*)

FALL	WINTER	SPRING
<input type="checkbox"/> Football	<input type="checkbox"/> Men Basketball	<input type="checkbox"/> Baseball
<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Women Basketball	<input type="checkbox"/> Men Track
<input type="checkbox"/> Women Volleyball	<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Women Track
<input type="checkbox"/> Men's Golf	<input type="checkbox"/>	<input type="checkbox"/> Women Soccer
<input type="checkbox"/> Women Golf	<input type="checkbox"/>	<input type="checkbox"/> Men's Soccer
<input type="checkbox"/> Softball	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INSURANCE

School Board Policy (#5143) requires that all students who participate in athletics be adequately covered by medical or accident insurance. 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 _____

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.

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 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.

PARENT / GUARDIAN SIGNATURE

Student-Athlete Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Name (First, MI, Last): _____ CMS Student ID # _____
Gender: ☐ M ☐ F Date of Birth: _____ Age: _____ Home Phone: _____

HIPPA / 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.

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 the athlete have trouble with hearing or 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, or 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

21. Are your periods regular (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 NCHSAA 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.

PARENT / GUARDIAN SIGNATURE

Student-Athlete Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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 Neuropsychologic 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	
		<u>Strenuous</u>	<u>Non-Strenuous</u>
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: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____

Signature: _____

MD PA NP

Physician's/Provider's Stamp

Date: _____

Approved: May 2008