SCS 2019-20 ATHLETIC PHYSICAL AUTHORIZATION FORM

LAST NAME ______ FIRST NAME ______ MIDDLE ______ GRADE 2019-2020 ______ DOB ______ AGE ______

STREET ADDRESS ______ CITY ______ ZIP CODE ______

FATHER/GUARDIAN ______ WORK PHONE ______ CELL PHONE ______

MOTHER/GUARDIAN ______ WORK PHONE ______ CELL PHONE ______

I. HEALTH QUESTIONS TO BE COMPLETED BY PARENT OR GUARDIAN

YES	NO	HEALTH QUESTIONS
		Does the athlete have any chronic illnesses (diabetes,, asthma, exercise asthma, kidney problems, etc? List:
		Is the athlete presently taking any medications or pills? List:
		Does the athlete have any allergies? (medicine, bees or other stinging insects, latex, etc.) List:
		Does the athlete have sickle cell trait?
		Has the athlete ever had a head injury, been knocked out, or had a concussion? Date:
		Has the athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?
		Has the athlete ever passed out or nearly passed out DURING exercise, emotion or startle?
		Has the athlete ever passed out or nearly passed out AFTER exercise?
		Has the athlete ever had extreme fatigue (been really tired) with exercise (different from other children)?
		Has the athlete ever had trouble breathing during exercise or a cough with exercise?
		Has the athlete ever been diagnosed with exercise induced asthma?
		Has a doctor ever told the athlete that they have high blood pressure?
		Has a doctor ever told the athlete that they have a heart infection?
		Has a doctor ever ordered an EKG, ECG, Echo Cardiogram, or other test for the athlete's heart.
		Has the athlete ever been told they have a heart murmur?
		Has the athlete ever had discomfort, pain, pressure in his/her heart during/after exercise or complained of heart racing or skipping beats?
		Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?
		Has the athlete ever had a stinger, burner, or pinched nerve?
		Has the athlete ever had any problems with their eyes or vision?
		Has the athlete ever sprained/strained, dislocated, fractured, broken, or had repeated swelling or injury to any bones or joints? ___ Head ___ Shoulder ___ Thigh ___ Neck ___ Elbow ___Knee ___Chest ___Hip ___ Forearm ___Shin/Calf ____ Back ___ Wrist ____Ankle ___Hand ___Foot
		Has the athlete ever had an eating disorder, or do you have any concerns about their eating habits or weight?
		Has the athlete ever been hospitalized or had surgery?
		Has the athlete had a medical problem since their last evaluation?
YES	**NO**	**FAMILY HISTORY**
		Has a family member had a sudden or unexpected death before the age of 50 (including SIDS (sudden infant death), or accidental death or drowning?
		Has any family member had unexplained heart attacks, fainting or seizures?
		Does the athlete have a father, mother, or brother with sickle cell disease?

PARENT OR GUARDIAN SIGNATURE ______ DATE ______

STUDENT'S NAME ______________________ DATE OF BIRTH ______________________

II. HEALTH SCREENING BY A LICENSED NC MEDICAL DOCTOR

BP ______________________

PULSE ______________________

HEIGHT ______________________

WEIGHT ______________________

SKIN ______________________

EYES/MOUTH ________________

CHEST/HEART
MURMUR/RYTHYM______________

LUNGS ______________________

SPINE ______________________

UPPER EXT. LEFT ________________

UPPER EXT. RIGHT _______________

LOWER EXT. LEFT _______________

LOWER EXT. RIGHT______________

OPTIONAL

HEENT __________________________

ABDOMINAL EXAM _______________

GENITALIA (MALES) ______________

HERNIA (MALES) ________________

VISION R 20/____
L 20/____

CORRECTED YES____ NO_____

III. CLEARANCE FOR PARTICPATION BY A LICENSED NC MEDICAL DOCTOR

____ CLEARED

____ CLEARED AFTER COMPLETINGG EVALUATION/REHABILITATION FOR ______________________________________

____ CLEARED WITH MEDICAL WAIVER ATTACHED FOR ____

____NOT CLEARED FOR

_____ COLLISION _____ CONTACT _____NON CONTACT _____STRENUOUS _____

_____ MODERATE STRENUOUS _____NON STRENUOUS

PHYSICIANS NOTES :

____
PHYSICIANS NAME PRINT

____ ____________________________
PHYSICIANS SIGNATURE DATE

License # ________________________________ MD. DO. PAC CRNP OR SNP CIRCLE ONE