



# SCS 2018–19 ATHLETIC PHYSICAL AUTHORIZATION FORM

LAST NAME	FIRST NAME	MIDDLE	GRADE 2018-2019	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 _____	UPPER EXT. LEFT _____	<b>OPTIONAL</b>
PULSE _____	UPPER EXT. RIGHT _____	HEENT _____
HEIGHT _____	LOWER EXT. LEFT _____	ABDOMINAL EXAM _____
WEIGHT _____	LOWER EXT. RIGHT _____	GENITALIA (MALES) _____
SKIN _____		HERNIA (MALES) _____
EYES/MOUTH _____		VISION R 20/____ L 20/____
CHEST/HEART MURMUR/RHYTHM _____		CORRECTED YES____ NO____
LUNGS _____		
SPINE _____		

**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