

**HIGH POINT FRIENDS SCHOOL  
STUDENT ATHLETIC PHYSICAL CLINIC  
PARTICIPATION FORM**

This form is to be filled out completely and filed in the office of the Athletic Director before the student can participate in the school athletic programs.

STUDENT: \_\_\_\_\_  
                    First                                    Middle                                    Last

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_

STUDENT'S ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PARENT'S NAME: \_\_\_\_\_ PHONE# \_\_\_\_\_

Do you currently have a private physician that you have seen within the last two years?  
 NO                       YES                      If yes, please list:

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

I certify that the information contained in this application is correct, and I agree to abide by the eligibility rules and regulations of the ISL Conference.

\_\_\_\_\_  
STUDENT'S SIGNATURE

\_\_\_\_\_  
DATE

PARENTAL PERMISSION

As a parent or legal guardian of the student listed above, I hereby give my consent for him/her to practice and play in the athletic events listed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I also grant permission for treatment deemed necessary for conditions arising during participation in these activities including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment.

I agree to the need of a screening medical examination and certify that the medical history is accurate to the best of my knowledge.

## Sports Participation History Form

Form Currently Recommended by the NCMS Sports Medicine Committee

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Athlete's Directions: Please review all questions with your parent or guardian and answer them to the best of your knowledge.

Physician's Directions: We recommend repeating the thirteen questions listed below and carefully reviewing details of any positive answers.

Yes	No	Don't Know	
			1. Has anyone in the athlete's family (grandmother, grandfather, mother, father, brother, sister) died suddenly before age 50?
			2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise?
			3. Has the athlete ever been told he/she has a heart murmur or heart problem?
			4. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?
			5. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?
			6. Does the athlete have a history of a concussion (getting knocked out)?
			7. Has the athlete ever suffered a heat-related illness (heat stroke)?
			8. Does the athlete have anything he/she wants to talk about to the doctor?
			9. Does the athlete have a chronic illness or see a doctor regularly for any particular problem?
			10. Does the athlete take any medicine?
			11. Is the athlete allergic to any medications or bee stings?
			12. Does the athlete have only one of any paired organs (eyes, ears, kidneys, testicles, ovaries, etc.)?
			13. Does the athlete wear contacts or eye glasses?
			14. Date of last tetanus booster. DATE: _____

Elaborate on any positive answer:

I have answered and reviewed the questions above and give permission for my child to participate in sports.

Signature of Parent or Guardian:

\_\_\_\_\_  
Date \_\_\_\_\_ Phone ( ) \_\_\_\_\_

(OVER)

## Examination

Patient's Name: \_\_\_\_\_ BP \_\_\_\_\_ WT \_\_\_\_\_

1. (Minimal Wt. \_\_\_\_\_) HT \_\_\_\_\_ Vision (R) \_\_\_\_\_ (L) \_\_\_\_\_

### 2. Musculoskeletal Exam

	NORMAL	ABNORMAL	RECORD laxity, weakness, instability, decrease, abnormal
Neck			
Knee			
Ankle			
Shoulder			
Feet			
Scoliosis/Spine			
Other Orthopedic Problems			

### 3. Cardiovascular Exam

	NORMAL	ABNORMAL	NOT DONE	COMMENTS
ENT				
Chest				
Abdomen				
Genitalia				
Skin				

4. **ASSESSMENT:**  No problems identified  Other \_\_\_\_\_

5. **RECOMMENDATIONS:**  Unlimited  Limited to Specific Sports  Deferred Until (e.g., Rehab. Recheck, Consultation, Lab, etc.)

6. **RE-EXAM:**  Yearly and after any injury that limits participation for greater than one week.

Other \_\_\_\_\_

I certify that I have examined the above student and that such examination revealed ( Conditions  No Conditions) that would prevent this student from participation in interscholastic sports.

Licensed to practice medicine in North Carolina?  Yes  No

Signature: \_\_\_\_\_ Phone# ( ) \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

If student is not qualified, list reasons for disqualification: \_\_\_\_\_

(The following are considered disqualifying until medical and parental releases are obtained: acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, hernia and musculoskeletal.)