

**Harnett County Schools
Athletics Pre-Participation Evaluation**

Student's Name _____ Sex: M F Age: _____ Date of Birth: _____
 Address: _____ Home Phone: _____
 Primary Emergency Contact: _____ Relationship: _____ Phone#: _____
 Secondary Emergency Contact: _____ Relationship: _____ Phone#: _____
 Personal Physician: _____ Address: _____ Phone#: _____
 Sport(s) _____

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

Physician's Directions: Please review the questions below and carefully review details of any positive answers.

History

		Yes	No	Don't Know
1.	Has anyone in your family died of a heart problems or sudden death before age 50?			
2.	Have you ever passed out or been dizzy during or after exercise?			
3.	Have you ever been told you had a heart murmur or heart problems?			
4.	Do you have asthma (wheezing), hay fever or coughing spells during or after activity?			
5.	Have you ever sprained/strained, dislocated, fractured, broken or had swelling or other injury of the following bones or joints? <input type="checkbox"/> Head/Skull <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Neck <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			
6.	Have you ever had a head injury or concussion (been knocked out)?			
7.	Have you ever suffered from heat related illness (heat stroke or heat exhaustion)?			
8.	Have you had a medical problem or injury since your last evaluation you would like to talk to the doctor about?			
9.	Do you have any chronic medical illness or see a doctor regularly for any problem?			
10.	Are you presently taking any medications, pills or dietary supplements?			
11.	Do you have any allergies (medicine, bees or other stinging insects, foods, latex)?			
12.	Do you have only one of any paired organs (eyes, kidneys, ears, testicles, ovaries, etc.)?			
13.	Do you wear contacts or glasses?			
14.	Last tetanus booster: _____ Date _____			

Elaborate on any positive answers: _____

Risk of Injury: 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 direction of an athletic coach employed by Harnett County Schools. We agree to follow the rules of the sport and the instructions of the coach in order to reduce the risk of injury and disease. However, we acknowledge and understand that neither the coach nor Harnett County Schools can fully eliminate the risk of injury in sports. Sports injuries can be severe and in some cases may result in permanent disability or death. We freely, knowingly, and willfully accept and assume the risk of injury that may occur from participation in athletics.

Release: In consideration of Harnett County Schools allowing the student-athlete to participate in athletics, we agree to release and hold Harnett County Schools, and their agents/employees harmless and indemnified from and against any and all claims, suits, or cases of action arising from or out of any injury that the student athlete may suffer from participation in athletics other than an injury from gross or willful negligence.

All information provided by me on this form is, to the best of my knowledge, correct and I give permission for my child to participate in school sports.

Parent/Guardian's Signature: _____ **Athlete's Signature:** _____ **Date:** _____

Note to Parents: This is a screening evaluation only and is not a complete physical examination. It does not substitute for regular exams with your child's physician. Annual check-ups with your physician are important for immunizations, health screening and guidance.

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Pre-Participation Evaluation (continued)

Name: _____ Age: _____ Date of Birth: _____

General Examination (Required):

1. Height _____ Weight _____ BP _____ / _____ Pulse _____ Vision: **R** 20 / _____ **L** 20 / _____

2. Cardiovascular Exam: _____ Normal _____ Abnormal **Comments:**
Murmur: _____ Yes _____ No

3. Musculoskeletal Exam: (Record laxity, weakness, instability, decreased ROM – if abnormal)

- Knee _____ Normal _____ Abnormal **Comments:**
- Ankle _____ Normal _____ Abnormal
- Shoulder _____ Normal _____ Abnormal
- Other orthopedic problems, e.g. neck, feet, scoliosis
_____ Normal _____ Abnormal

4. **Optional Exam:** (Should be completed if history is positive) **Comments:**

- ENT _____ Normal _____ Abnormal
- Chest _____ Normal _____ Abnormal
- Abdomen _____ Normal _____ Abnormal
- Genitalia _____ Normal _____ Abnormal
- Skin _____ Normal _____ Abnormal

5. Clearance (Required)

_____ Student cleared to play / participate in sports listed.

_____ Student cleared after completing evaluation / rehabilitation for: _____

_____ Student not cleared for: _____ Collision Sports _____ Contact Sports _____ Non-contact Sports
_____ Strenuous _____ Moderately Strenuous _____ Non-Strenuous

Due to: _____

_____ Reexamine yearly or after any injury that limits participation for greater than one week.

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.

Are you licensed to practice in the United States? _____ Yes _____ No

Physician's Signature: _____ **Date:** _____

Office Address: _____ **Phone #:** _____

If the student is not qualified, list reasons for disqualifications: _____

_____.
The following are considered disqualifying until medical and parental releases are obtained: acute infections, obvious growth retardation, diabetes, jaundice, severe visual or audio impairments, enlarged spleen or liver, hernia, musculoskeletal deformity associated with functional loss, history of convulsion or concussions, absence of one kidney, eye, or ovary, etc.