COASTAL CHILDREN'S CLINIC

Currently Recommended by the NCSM Sports Medicine Committee

SPORTS PARTICIPATION HISTORY FORM

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?
		2A	Has the athlete ever stopped exercising because of dizziness or passed out during exercise?
		2B	Has the athlete ever been told he/she has a heart murmur or heart problem?
		3.	Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise?
		4.	Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint?
		5.	Does the athlete have a history of a concussion (getting knocked out)?
		6.	Has the athlete ever suffered a heat-related illness (heat stroke)?
		7.	Does the athlete have anything he/she wants to talk about to the doctor?
		8.	Does the athlete have a chronic illness or see a doctor regularly for any particular problem?
		9.	Does the athlete take any medicine?
		10.	Is the athlete allergic to any medications or bee stings?
		11.	Does the athlete have only one of any paired organs (eyes, ears, kidneys, testicles, ovaries, etc.)?
		12.	Does the athlete wear contacts or eye glasses?
		13.	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 _____

1. BP_____ WT_____ (Minimal wt _____) HT _____ Vision (R)_____ (L) _____

2. MUSCULOSKELETAL EXAM

	NORMAL	ABNORMAL	RECORD laxity, weakness, instability, decreased ROM - if abnormal
Neck			
Knee			
Ankle			
Shoulder			
Feet			
Scoliosis/Spine			
Other Orthopedic Problems			

3. CARDIOVASCULAR EXAM

	NORMAL	ABNORMAL	NOT DONE	COMMENTS
ENT				
Chest				
Abdomen				
Genitalia				
Skin				

9. ASSESSMENT: ❑ No problems identified ❑ Other _____

10. RECOMMENDATIONS: ❑ Unlimited ❑ Limited to specific sports ❑ Deferred until: (e.g., rehab., recheck, consultation, lab, etc.)

11. 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 # (252) 6332900 Date: _____

Coastal Children's Clinic 703 Newman Road New Bern, NC 28562

If student is not qualified, list reasons for disqualification: _____

(The following are considered disqualifying until medical conditions 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, musculoskeletal deformity associated with functional loss, history of convulsions or concussions, absence of one kidney, eye, testicle, or ovary, etc.)