■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents Name:			ntment. of birth:	NORTH CAROLINA HEALTH &	HIGH SCHOOL SAFETY
Name: Date form completed: Sex assigned at birth (F, M, or intersex):	Sport(s): _	Dule C	, Dilili		TH.
How do you identify your gender (optional)? (F, M, nor	n-binary, or and	other gender):			
Have you had COVID-19? (optional; check one): □	Υ□N				
Have you been immunized for COVID-19? (optional	•	□ Y □ N If yes, hav	,		o shots
List past and current medical conditions.					
Have you ever had surgery? If yes, list all past surgice	al procedures.				
Medicines and supplements: List all current prescript	tions, over-the-	counter medicines, and :	supplements (herba	l and nutrition	ial).
Do you have any allergies? If yes, please list all you	r allergies (ie, ı	medicines, pollens, food	stinging insects).		
Patient Health Questionnaire Version 4 (PHQ-4) Over the last 2 weeks, how often have you been both Feeling nervous, anxious, or on edge 0 Not being able to stop or control worrying 0 Little interest or pleasure in doing things 0 Feeling down, depressed, or hopeless 0 (A sum of ≥3 is considered positive on either sections)	Not at all 0 0 0 0 0 0 0 0	Several days 1 1 1	Over half the days 2 2 2 2 2	Nearly ever 3 3 3 3	
GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes No	HEART HEALTH QUESTI (CONTINUED)			Yes No
Do you have any concerns that you would like to discuss with your provider?		9. Do you get light-h than your friends		of breath	
Has a provider ever denied or restricted your		10. Have you ever had		AMILY Unsure	Yes No
participation in sports for any reason? 3. Do you have any ongoing medical issues or recent illness?		11. Has any family me		of	ies No
HEART HEALTH QUESTIONS ABOUT YOU	Yes No		n death before age 3		
4. Have you ever passed out or nearly passed out during or after exercise?		crash)?	owning or unexplaine		
Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			ur tamily have a gene 1 as hypertrophic carc Marfan syndrome, arı	dio-	
Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		mogenic right vent (ARVC), long QT s	ricular cardiomyopath yndrome (LQTS), shor Brugada syndrome, o	ny t QT	
7. Has a doctor ever told you that you have any heart problems?			polymorphic ventricul		
 Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. 		13. Has anyone in you or an implanted de	r family had a pacem fibrillator before age		

	NE AND JOINT QUESTIONS	Yes	No	MEDICAL QUESTIONS (CONTINUED)	Yes	N
14.	Have you ever had a stress fracture or an injury to a			25. Do you worry about your weight?		Γ
	bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?			26. Are you trying to or has anyone recommended that you gain or lose weight?		Ī
15.	Do you have a bone, muscle, ligament, or joint injury that bothers you?			27. Are you on a special diet or do you avoid certain types of foods or food groups?		
MEI	DICAL QUESTIONS	Yes	No	28. Have you ever had an eating disorder?		
16.	Do you cough, wheeze, or have difficulty breathing during or after exercise?			MENSTRUAL QUESTIONS (optional) N/A 29. Have you ever had a menstrual period?	Yes	No
17.	Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?	E		30. How old were you when you had your first menstrual period?		JL
18.	Do you have groin or testicle pain or a painful bulge			31. When was your most recent menstrual period?		
1.0	or hernia in the groin area?	L		32. How many periods have you had in the past 12 months?		
19.	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?			Explain "Yes" answers here.	<u> </u>	
20.	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?					
21.	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?					
22.	Have you ever become ill while exercising in the heat?					
23.	Do you or does someone in your family have sickle cell trait or disease?					
	Have you ever had or do you have any problems					

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PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name:	Date	of bir	th:	

PHYSICIAN REMINDERS

- 1. Consider additional questions on more-sensitive issues.
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- 2. Consider reviewing questions on cardiovascular symptoms (Q4-Q13 of History Form).

	MINAT		6 4u		car dio rascu	liar symptoms	(4. 4.3 011						
		ON			\\/aidht								
Heigh			, ,		Weight:				1.00/				
BP:	/		(/)	Pulse:	V	ision: R 20/		L 20/	Corre	ected: TY		FINDINGS
MEDIO											NORMAL	ABNORMAL	FINDINGS
• M		_	() 1		. 0	d palate, pectu		arachno da	ctyly, hype	rlaxity,			
Eyes,	ears, no pils equ	se, ar	nd throa										
Lympl	n nodes												
Heart	1				· ·								
• M	urmurs	(auscu	ıltation	standir	ng, auscultation	supine, and	t Valsalva mane	euver)					
Lungs													
Abdo	men												
l .	erpes si		virus (H	SV), les	sions suggestive	of methicillin-re	esistant <i>Staph</i>	уІососси	s aureus (1	MRSA), or			
Neur	ological												
MUSC	ULOS	ELET	AL								NORMAL	ABNORMAL	FINDINGS
Neck													
Back													
Shoul	der and	arm											
Elbow	and fo	rearm											
Wrist	hand,	and fi	ngers										
Hip a	nd thigh												
Knee													
Leg a	nd ankl	9									1		
Foota	and toes	5											
Functi	onal												
• D	ouble-le	g squa	it test,	single-le	eg squat test, a	and box drop o	r step drop tes	t					
^a Consi	der ele	trocar	diograp	hy (EC	CG), echocardi	ography, refer	ral to a cardiol	ogist for a	abnormal c	ardiac histo	ory or examina	ation findings,	or a combi-
nation (of those												
Name o	of health	care	profess	ional (_l	print or type):_						Date of	exam:	
Addres	s:									Pho	one:		
Signatur	e of he	alth c	are pro	fession	nal:							, MD, [OO, NP, or PA

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■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name:	Date of birth:	_
□ Medically eligible for all sports without restriction		
□ Medically eligible for all sports without restriction with recommendations for furth	er evaluation or treatment of	
		_
□ Medically eligible for certain sports		_
□ Not medically eligible pending further evaluation		_
□ Not medically eligible for any sports		
Recommendations:		_
		_
I have examined the student named on this form and completed the preparapparent clinical contraindications to practice and can participate in the spectrum examination findings are on record in my office and can be made available arise after the athlete has been cleared for participation, the physician may and the potential consequences are completely explained to the athlete (as	ort(s) as outlined on this form. A copy of to the school at the request of the parent rescind the medical eligibility until the parent	the p hysical ts. If c onditions
Name of health care professional (print or type):	Date <u>of exam:</u>	
Address:	Phone:	
Signature of health care professional:		_, MD, DO, NP, or PA
SHARED EMERGENCY INFORMATION		
Allergies:		_
		_
Medications:		_
		- -
		_
Other information:		_
		_
Emergency contacts:		_
		_

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