

**Charlotte-Mecklenburg Schools  
Middle School Student-Athlete Pre-Participation Form**

**\* Please take the time, read through the questions, and answer to the best of your knowledge.\***

**PERSONAL INFORMATION**

Name (First, MI, Last): \_\_\_\_\_ CMS Student ID # \_\_\_\_\_  
 Gender:  M  F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Parent(s) / Legal Guardian(s) Residing With: \_\_\_\_\_ Who has legal custody? \_\_\_\_\_  
 Father's Name: \_\_\_\_\_ Phone (Work or Cellular): \_\_\_\_\_  
 Mother's Name: \_\_\_\_\_ Phone (Work or Cellular): \_\_\_\_\_  
 Street Address: \_\_\_\_\_ Apartment / Unit # \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name (First, MI, Last): \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ Apartment / Unit # \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Primary Phone: \_\_\_\_\_ Alternate Phone (Work or Cellular): \_\_\_\_\_  
 Family Physician/Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Preferred Hospital: \_\_\_\_\_ Permission to Transport:  Yes  No

**SPORT (\*check all sports you are considering to participate in\*)**

FALL	WINTER	SPRING
<input type="checkbox"/> Football	<input type="checkbox"/> Men Basketball	<input type="checkbox"/> Baseball
<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Women Basketball	<input type="checkbox"/> Men Track
<input type="checkbox"/> Women Volleyball	<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Women Track
<input type="checkbox"/> Men's Golf	<input type="checkbox"/>	<input type="checkbox"/> Women Soccer
<input type="checkbox"/> Women Golf	<input type="checkbox"/>	<input type="checkbox"/> Men's Soccer
<input type="checkbox"/> Softball	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**INSURANCE**

School Board Policy (#5143) requires that all students who participate in athletics be adequately covered by medical or accident insurance. We certify that we have purchased and will maintain in full force and effect during student-athlete's participation in athletics the following insurance policy:

Check One:  School Accident Insurance  Personal Insurance Company

Name of Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Insurance Phone for Authorization \_\_\_\_\_ Policy Holder \_\_\_\_\_

**RELEASE**

In consideration of CMS allowing the above-named individual to participate in athletics, we agree to release and hold CMS, its athletic coaches, and other employees free, harmless and indemnified from and against any and all claims, suits, or causes of action arising from or out of injury that the student-athlete may suffer from participation in athletics other than an injury from gross or willful negligence.

**ASSUMPTION OF RISK**

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 the instructions of the coach in order to reduce the risk of injury to the student and other athletes. However, we acknowledge and understand that neither the coach nor CMS can eliminate the risk of injury in sports. Injuries may and do occur. Sports injuries can be severe and in some cases may result in permanent disability or even death. We freely, knowingly, and willfully accept and assume the risk of injury that might occur from participation in athletics.

**PARENT / GUARDIAN SIGNATURE**

Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (First, MI, Last): \_\_\_\_\_ CMS Student ID # \_\_\_\_\_  
 Gender:  M  F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**HIPPA / FERPA RELEASE**

The above named student-athlete has opted his/her rights under the US Department of Health and Human Resources guidelines. By signing this release, the student-athlete allows sharing of medical information between the Sports Medicine Staff (team physicians and medical staff, athletic trainers, and student assistants), the CMS Athletics Staff (Athletic Director and Coaches), CMS Administration and his/her medical provider(s). In the event of an emergency situation, information may be shared with emergency medical personnel. Every reasonable effort will be made to protect this information. It is understood that once this medical information is disclosed, it is no longer protected under the HIPAA/FERPA guidelines.

**MEDICAL HISTORY**

**\* Please take the time, read through the questions, and answer to the best of your knowledge.\***

The following questions should be answered by the student-athlete with the assistance of a parent/guardian. Explain any "Yes" answers below. If additional space is needed, please attach to this form.

<u>General Medical History</u>	YES	NO
1. Does the athlete have a chronic illness or see a doctor regularly for any particular problem? -----	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the athlete had surgery other than a tonsillectomy? ---	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the athlete ever been hospitalized? -----	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the athlete have sickle cell trait? -----	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the athlete have history of seizures? -----	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the athlete have only one of any paired organ (eyes, ears, kidneys, testicles, ovaries, etc.)? -----	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have any skin problems other than acne? -----	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the athlete ever suffered a heat-related illness (heat exhaustion or heat stroke)?-----	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever had a head injury, been knocked out, lost your memory, had your 'bell rung', or concussion?---	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you had mononucleosis or any significant illness in the last 60 days? -----	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you wear glasses or contacts? -----	<input type="checkbox"/>	<input type="checkbox"/>
12. Does the athlete have trouble with hearing or wear hearing aid(s)? -----	<input type="checkbox"/>	<input type="checkbox"/>
13. Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the-counter)? -----	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you ever taken any supplements or vitamins to help with weight loss/gain or improve performance? -----	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have any allergies (seasonal, insects, food, or medicines)? -----	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you want to weigh more or less than you do now? ---	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you lose weight regularly to meet weight requirements for you sport or other reasons? -----	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you feel stressed out, tired, or depressed? -----	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever been denied or restricted from participation in sports? -----	<input type="checkbox"/>	<input type="checkbox"/>
20. Are there any other issues you would like to discuss with a healthcare professional? -----	<input type="checkbox"/>	<input type="checkbox"/>
<b>FEMALES ONLY</b>		
21. Are your periods regular (every month)? -----	<input type="checkbox"/>	<input type="checkbox"/>
22. Are your periods heavy? -----	<input type="checkbox"/>	<input type="checkbox"/>

<u>Cardiovascular History</u>	YES	NO
1. Do you cough, wheeze or have extreme trouble breathing with exercise? -----	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you use an inhaler? -----	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever passed out/nearly passed out during/ after exercise? <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever been dizzy during or after exercise? -----	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever had chest pain/discomfort during or after exercise? --	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you tire more easily or more quickly than your friends during exercise? -----	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever had a racing of your heart or skipped heartbeats? ---	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever been told you had a heart murmur? -----	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever been told you have high blood pressure? -----	<input type="checkbox"/>	<input type="checkbox"/>
10. Has any member of your family:		
• Died of heart problems or sudden death before age 50? -----	<input type="checkbox"/>	<input type="checkbox"/>
• Been told they had a serious heart problem before age 50? -----	<input type="checkbox"/>	<input type="checkbox"/>
• Been told they had Marfan's syndrome? -----	<input type="checkbox"/>	<input type="checkbox"/>
• Hypertrophic or dilated cardiomyopathy? -----	<input type="checkbox"/>	<input type="checkbox"/>
• Heart rhythm abnormality? -----	<input type="checkbox"/>	<input type="checkbox"/>
<b>Orthopedic History</b>		
1. Has the athlete ever broken or fractured any bones? -----	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the athlete ever subluxed or dislocated any joint? -----	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a stinger, burner, or pinched nerve? ---	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had any other problems related to your:		
• Neck, spine, or back? -----	<input type="checkbox"/>	<input type="checkbox"/>
• Shoulders? -----	<input type="checkbox"/>	<input type="checkbox"/>
• Elbows? -----	<input type="checkbox"/>	<input type="checkbox"/>
• Wrists, hands, fingers? -----	<input type="checkbox"/>	<input type="checkbox"/>
• Hips? -----	<input type="checkbox"/>	<input type="checkbox"/>
• Knees? -----	<input type="checkbox"/>	<input type="checkbox"/>
• Ankles, feet, or toes? -----	<input type="checkbox"/>	<input type="checkbox"/>
• Other? -----	<input type="checkbox"/>	<input type="checkbox"/>

Please explain "Yes" answers in the space below. Please put date(s) of any injuries along with explanation: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CERTIFICATION / MEDICAL AUTHORIZATION**

We certify that all of the information provided by us on this form is correct. We agree by the rules of the NCHSAA and CMS. We give our consent for the student-athlete to receive a medical screening prior to participation in athletics and **acknowledge that this is simply a screening evaluation and not suitable for regular health care**. If the student-athlete is injured while participating in athletics and CMS is unable to contact the parent, we grant CMS permission and the authority to obtain necessary medical care and/or treatment for the student's injury including first aid, CPR, medical or surgical treatment recommended by a physician and we accept the financial responsibility for such medical care or treatment.

**PARENT / GUARDIAN SIGNATURE**

Student-Athlete Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (First, MI, Last): \_\_\_\_\_ CMS Student ID # \_\_\_\_\_

**PHYSICAL EXAMINATION: To be completed by a Physician, Physician's Assistant, or Nurse Practitioner ONLY**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ Blood Pressure (sitting): (arm) \_\_\_\_\_ (leg) \_\_\_\_\_  
 Vision: Right 20 / \_\_\_\_\_ Left 20 / \_\_\_\_\_ Corrected: Y N Body Fat% (opt.): \_\_\_\_\_ UA (opt.): \_\_\_\_\_

	Normal	Abnormal Findings	Initials
<b>General Medical</b>			
Appearance/Emotional Affect			
Head/Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart (standing/supine)			
Pulses (include femoral)			
Lungs			
Abdomen (include liver, spleen)			
Skin			
Neurologic (Balance, Coordination)			
Genitalia (males only)			
<b>Orthopedic</b> Record if any laxity, weakness, instability, decreased ROM			
Cervical/Spine			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
<b>Cardiologic (optional)</b>			
EKG			
Echocardiogram			
<b>Neurologic (optional)</b>			
Baseline Neuropsychologic Testing			

**CLEARANCE**

I, the undersigned, certify that I have examined this student-athlete and find him/her medically:

**Cleared**

**Deferred until:** (e.g. Rehab, consultation, lab, referral, etc.) \_\_\_\_\_

**May participate in the following sport(s) ONLY:** (CHECK ALL THAT APPLY)

\_\_\_\_\_ Contact/Collision \_\_\_\_\_ Limited Contact \_\_\_\_\_ Non-Contact/Strenuous \_\_\_\_\_ Non-Contact/Non-Strenuous

<b>Classification of Sports by Contact</b>			
Contact/Collision	Limited Contact	Non-Contact	
		<u>Strenuous</u>	<u>Non-Strenuous</u>
Football	Baseball/Softball	Discus, Javelin, Shot Put	Golf
Soccer	Basketball	Running/Cross Country	
	Cheerleading	Swimming	
	Volleyball	Tennis	
	High Jump, Pole Vault	Strength Training	

Please specify each condition requiring clearance before participating in a sport in the classification checked above:

\_\_\_\_\_

**Not cleared**

Due to: \_\_\_\_\_

*The following are considered disqualifying, but not limited to, until medical and parental releases are obtained: Atlantoaxial instability; Bleeding disorder; Hypertension; Dysrhythmia; Mitral valve prolapse; Acute infections; Obvious growth retardation; Diabetes mellitus; Jaundice; Severe visual or auditory impairment; Pulmonary insufficiency; Organ transplant recipient; Enlarged liver or spleen; Hernia; Musculoskeletal deformity associated with functional loss; History of convulsions or repeated concussions; Absence of one kidney, eye, testicle, ovary, etc.*

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

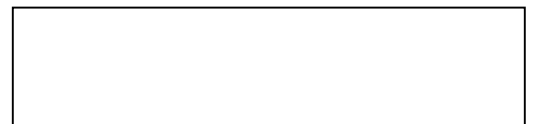
**Street Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Physician's/Provider's Stamp**



MD PA NP

**Date:** \_\_\_\_\_