

Charlotte-Mecklenburg Schools
Middle School Student-Athlete Pre-Participation Form
TAB THROUGH FORM & TYPE INFORMATION OR PRINT FORM AND WRITE INFORMATION

PERSONAL & EMERGENCY CONTACT INFORMATION

Student-Athlete's Name (First, MI, Last): _____ CMS Student ID # _____

Gender: ☐ M ☐ F Date of Birth: _____ Age: _____ Home Phone: _____

Resides At Street Address: _____ City: _____ State: _____ Zip Code: _____ County: _____

Father's Name: _____ Daytime Phone: _____ Cell Phone: _____
 Street Address: _____ City: _____ State: _____ Zip Code: _____ County: _____

Mother's Name: _____ Daytime Phone: _____ Cell Phone: _____
 Street Address: _____ City: _____ State: _____ Zip Code: _____ County: _____

If applicable... Guardian's
 Name: _____ Daytime Phone: _____ Cell Phone: _____
 Street Address: _____ City: _____ State: _____ Zip Code: _____ County: _____

• If student-athlete resides with other than parent(s), attach legal documentation of custody (guardianship or affidavit provided by Student Placement)

Failure to provide accurate and up-to-date residence information may be grounds for loss of athletic eligibility

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

Fall	Winter	Spring
<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Basketball - Boy's	<input type="checkbox"/> Baseball
<input type="checkbox"/> Football	<input type="checkbox"/> Basketball - Girl's	<input type="checkbox"/> Soccer - Boy's
<input type="checkbox"/> Golf - Boy's	<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Soccer - Girl's
<input type="checkbox"/> Golf - Girl's		<input type="checkbox"/> Track - Boy's
<input type="checkbox"/> Softball		<input type="checkbox"/> Track - Girl's
<input type="checkbox"/> Volleyball - Girl's		

INSURANCE

School Board Policy JLA requires that all students who participate in athletics be adequately covered by medical or accident insurance. We acknowledge that it is the signed responsibility to notify CMS of any changes that occur to the personal insurance policy below and affect the procedures in which the above-named individual may receive treatment; this includes loss of coverage. 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-athlete 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.

HIPAA / 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.

SEVENTH GRADE ENTRY

- This is my _____ consecutive semester at _____ Middle School
- I initially entered the seventh grade in the fall of (yr.) _____
- Last semester I attended _____ School in City _____ State _____

Parent/Guardian Initials: _____ Student-Athlete Initials: _____

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.

General Medical History

- | | 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 athlete have trouble with hearing/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/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"/> |

FEMALES ONLY

- | | YES | NO |
|---|--------------------------|--------------------------|
| 21. Are your periods irregular (not every month)? ----- | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Are your periods heavy? ----- | <input type="checkbox"/> | <input type="checkbox"/> |

Cardiovascular History

- | | 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"/> |
| 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"/> |

Orthopedic History

- | | YES | NO |
|---|--------------------------|--------------------------|
| 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 NCDPI 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.

We (student and parents) certify that the home address shown in this document is the student's sole bona fide residence, and we will notify the school principal immediately of any change in residence, since such a move may alter the eligibility status of the student athlete. All information contained in this form is accurate and correct.

Student-Athlete: _____	Date: _____
(Signature)	
Parent/Guardian: _____	Date: _____
(Please Print Name)	
Parent/Guardian: _____	Date: _____
(Signature)	



**Page 3 of this document must be completed by a
Physician, Physician's Assistant or Nurse Practitioner**



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
General Medical			
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)			
Orthopedic Record if any laxity, weakness, instability, decreased ROM			
Cervical/Spine			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			
Cardiologic (optional)			
EKG			
Echocardiogram			
Neurologic (optional)			
Baseline Neuropsychological 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

Classification of Sports by Contact			
Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-Strenuous
<input type="checkbox"/> Football	<input type="checkbox"/> Baseball/Softball	<input type="checkbox"/> Discus, Javelin, Shot Put	<input type="checkbox"/> Golf
<input type="checkbox"/> Soccer	<input type="checkbox"/> Basketball	<input type="checkbox"/> Running/Cross Country	
	<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Swimming	
	<input type="checkbox"/> Volleyball	<input type="checkbox"/> Tennis	
	<input type="checkbox"/> High Jump, Pole Vault	<input type="checkbox"/> 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: _____

Address: _____

Phone: _____

Signature _____ MD PA NP

Physician Office Stamp:

Date of exam: _____