

LAKE NORMAN CHRISTIAN SPORTS MEDICAL FORM (Confidential)

(to be completed by parent/guardian)

Because the malpractice question has come to the forefront, many hospitals and doctors will not treat a child without parental consent. It is requested that you complete the information below so that if your child requires a visit to the hospital while under the supervision of the school, this will allow the hospital to treat the injury.

EMERGENCY INFORMATION

Name _____ Sport(s) _____ Sex: M ___ F ___
Grade _____ Age _____ Date of Birth ____/____/____
Parents' Name(s) _____
Father's SS# _____ Mother's SS# _____
Father's Telephone Information (H) _____ (W) _____ (C) _____
Mother's Telephone Information (H) _____ (W) _____ (C) _____
Emergency Contact Person: Name _____ Telephone Information _____
Insurance Company _____ Policy and Group #'s _____
ALLERGIES: _____

TRANSPORTATION AUTHORIZATION

Since school-related transportation to and from certain sports contests and practices is not always possible, LKNC must have parental approval for students to ride with other parents or coaches. Parents must not hold Lake Norman Christian School or its representatives liable in case of accident or injury.

TMA/TSSAA Pre-Participation Medical Evaluation Form

(Explain all "Yes" Answers on Back of Form) YES NO

1. Have you ever been hospitalized? ___ ___
Have you ever had surgery? ___ ___
2. Are you presently taking any medications? ___ ___
3. Have you ever passed out during exercise? ___ ___
4. Have you ever been dizzy during or after exercise? ___ ___
Do you tire more quickly than your friends during exercise? ___ ___
Have you ever had high blood pressure? ___ ___
Have you ever been told that you have a heart murmur? ___ ___
Have you ever had a racing of your heart or skipped heartbeats? ___ ___
Has anyone in your family died of heart problems or a sudden death before the age of 50? ___ ___
5. Do you have any skin problems (itching, rashes, acne)? ___ ___
6. Have you ever had a head injury? ___ ___
Have you ever had a seizure? ___ ___
Have you ever had a stinger, burner, or pinched nerve? ___ ___
7. Have you ever had heat or muscle cramps? ___ ___
Have you ever been dizzy or passed out in the heat? ___ ___
8. Do you have trouble breathing or do you cough during or after activities? ___ ___
9. Do you use special equipment (pads, braces, neck roll, mouth/eye guard)? ___ ___
10. Have you had any problems with your eyes or your vision? ___ ___
Do you wear glasses or contacts or protective eyewear? ___ ___
11. Have you ever sprained/strained/ dislocated/fractured/broken or had repeated swelling
Of any bone or joint? ___ Head ___ Thigh ___ Neck ___ Elbow ___ Knee ___ Chest
___ Forearm ___ Shin/Calf ___ Back ___ Wrist ___ Ankle ___ Hip ___ Hand ___ Foot
12. Have you ever had any other medical problems (Infectious mononucleosis, diabetes)? ___ ___
13. Have you had a medical problem since your last evaluation? ___ ___
14. When was your last tetanus shot? _____ measles immunization? _____
15. When was your first menstrual period? _____ Last period _____
What was the longest time between your periods last year? _____

I hereby state that, to the best of my knowledge, my answers to the above are correct, and I give my consent for student athletic participation, treatment, and transportation.

Signature of Parent/Guardian _____ **Date** _____

Student Name _____

-Participation Medical Evaluation Form

(to be completed by physician)

General Physical Examination *Examiner* _____

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision R 20 / _____ L 20/ _____ Corrected ____ Yes ____ No Pupils _____

_____ Normal _____ Abnormal Findings

Ear, Nose, and Throat _____

Heart _____

Skin / Lymphatics _____

Abdominal _____

Genitalia / Hernia _____

Musculoskeletal Examination *Examiner* _____

Upper Extremities _____

Lower Extremities _____

Flexibility _____

Optional Lab

Urine Sugar _____

Urine Protein _____

Urine Hematest _____

Official Recommendation

A. This athlete _____ may _____ may not compete in athletics/physical education based on the data gathered from this exam.

B. Prior to participation, treatment or follow-up on the following is recommended:

C. Recommend further consultation with _____

_____ Date _____

Signature of Physician / Nurse Practitioner