

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

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**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)



## Instructions for Completing the NCHSAA Student-Athlete Preparticipation Physical Evaluation (PPE)

In order to be medically eligible for participation in practice or in interscholastic athletic contests, a student must have a completed NCHSAA PPE and submit it to the school. The PPE is four (4) pages in length and includes the **History Form**, the **Physical Examination Form**, and the **Medical Eligibility Form**.

The PPE **History Form** (pages 1-2) is completed and signed by the parent or legal custodian on behalf of the student-athlete. The completed and signed PPE History Form must then be presented to the examining Licensed Medical Professional (LMP) (physician licensed to practice medicine (MD/DO), nurse practitioner or physician assistant) for review when they fill out the Physical Examination Form.

The completed PPE **Physical Examination Form** (page 3) is signed and dated by the LMP who performed the examination. The physical examination builds on information obtained in the medical history.

The PPE **Medical Eligibility Form** (page 4), which is also signed and dated by the LMP, indicates the student-athlete is either medically eligible or not medically eligible for sports participation.



## Student-Athlete COVID Questionnaire

Student-Athlete's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

COVID RELATED QUESTIONS ABOUT THE STUDENT-ATHLETE	YES	NO	NA
1. Since January 1, 2020 have you been told that you have had a positive test for COVID-19, <b>OR</b> have you been told by a medical professional, your school, or local health department that you have had to quarantine (stay home) due to concern that you had COVID-19 symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If the answer to 1 was "Yes", has the required <i>Return to Play Form: COVID-19 Infection Medical Clearance Releasing The Student-Athlete to Resume Full Participation in Athletics</i> been completed?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you been fully vaccinated against COVID?	<input type="checkbox"/>	<input type="checkbox"/>	



## ■ PREPARTICIPATION PHYSICAL EVALUATION

### HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex: M/F \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). \_\_\_\_\_

#### Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box next to appropriate number)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		



## ■ PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

#### PHYSICIAN REMINDERS

- 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ ( _____ / _____ )	Pulse: _____	Vision: R 20/____ L 20/____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>		

<sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

## ■ 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 further 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 preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Other information: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Emergency contacts: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_





## ■ EVALUACIÓN FÍSICA PREVIA A LA PARTICIPACIÓN

### FORMULARIO DE HISTORIAL CLÍNICO

Nota: Complete y firme este formulario (con la supervisión de sus padres si es menor de 18 años) antes de acudir a su cita.

Nombre: \_\_\_\_\_ Fecha de nacimiento: \_\_\_\_\_

Fecha del examen médico: \_\_\_\_\_ Deporte(s): \_\_\_\_\_

Sexo que se le asignó al nacer (F, M o intersexual): \_\_\_\_\_ ¿Con cuál género se identifica? (F, M u otro): \_\_\_\_\_

Mencione los padecimientos médicos pasados y actuales que haya tenido. \_\_\_\_\_

¿Alguna vez se le practicó una cirugía? Si la respuesta es afirmativa, haga una lista de todas sus cirugías previas. \_\_\_\_\_

Medicamentos y suplementos: Enumere todos los medicamentos recetados, medicamentos de venta libre y suplementos (herbolarios y nutricionales) que consume. \_\_\_\_\_

¿Sufre de algún tipo de alergia? Si la respuesta es afirmativa, haga una lista de todas sus alergias (por ejemplo, a algún medicamento, al polen, a los alimentos, a las picaduras de insectos). \_\_\_\_\_

#### Cuestionario sobre la salud del paciente versión 4 (PHQ-4)

Durante las últimas dos semanas, ¿con qué frecuencia experimentó alguno de los siguientes problemas de salud? (Encierre en un círculo la respuesta)

	Ningún día	Varios días	Más de la mitad de los días	Casi todos los días
Se siente nervioso, ansioso o inquieto	0	1	2	3
No es capaz de detener o controlar la preocupación	0	1	2	3
Siente poco interés o satisfacción por hacer cosas	0	1	2	3
Se siente triste, deprimido o desesperado	0	1	2	3

(Una suma  $\geq 3$  se considera positiva en cualquiera de las subescalas, [preguntas 1 y 2 o preguntas 3 y 4] a fin de obtener un diagnóstico).

#### PREGUNTAS GENERALES

(Dé una explicación para las preguntas en las que contestó "Sí", en la parte final de este formulario. Encierre en un círculo las preguntas si no sabe la respuesta).

	Sí	No
1. ¿Tiene alguna preocupación que le gustaría discutir con su proveedor de servicios médicos?		
2. ¿Alguna vez un proveedor de servicios médicos le prohibió o restringió practicar deportes por algún motivo?		
3. ¿Padece algún problema médico o enfermedad reciente?		
PREGUNTAS SOBRE SU SALUD CARDIOVASCULAR		
	Sí	No
4. ¿Alguna vez se desmayó o estuvo a punto de desmayarse mientras hacía, o después de hacer, ejercicio?		

#### PREGUNTAS SOBRE SU SALUD

##### CARDIOVASCULAR (CONTINUACIÓN)

	Sí	No
5. ¿Alguna vez sintió molestias, dolor, compresión o presión en el pecho mientras hacía ejercicio?		
6. ¿Alguna vez sintió que su corazón se aceleraba, palpitaba en su pecho o latía intermitentemente (con latidos irregulares) mientras hacía ejercicio?		
7. ¿Alguna vez un médico le dijo que tiene problemas cardíacos?		
8. ¿Alguna vez un médico le pidió que se hiciera un examen del corazón? Por ejemplo, electrocardiografía (ECG) o ecocardiografía.		
9. Cuando hace ejercicio, ¿se siente mareado o siente que le falta el aire más que a sus amigos?		
10. ¿Alguna vez tuvo convulsiones?		

PREGUNTAS SOBRE LA SALUD CARDIOVASCULAR DE SU FAMILIA		Si	No
11.	¿Alguno de los miembros de su familia o pariente murió debido a problemas cardíacos o tuvo una muerte súbita e inesperado o inexplicable antes de los 35 años de edad (incluyendo muerte por ahogamiento o un accidente automovilístico inexplicable)?		
12.	¿Alguno de los miembros de su familia padece un problema cardíaco genético como la miocardiopatía hipertrófica (HCM), el síndrome de Marfan, la miocardiopatía arritmogénica del ventrículo derecho (ARVC), el síndrome del QT largo (LQTS), el síndrome del QT corto (SQTS), el síndrome de Brugada o la taquicardia ventricular polimórfica catecolaminérgica (CPVT)?		
13.	¿Alguno de los miembros de su familia utilizó un marcapasos o se le implantó un desfibrilador antes de los 35 años?		
PREGUNTAS SOBRE LOS HUESOS Y LAS ARTICULACIONES		Si	No
14.	¿Alguna vez sufrió una fractura por estrés o una lesión en un hueso, músculo, ligamento, articulación o tendón que le hizo faltar a una práctica o juego?		
15.	¿Sufre alguna lesión ósea, muscular, de los ligamentos o de las articulaciones que le causa molestia?		
PREGUNTAS SOBRE CONDICIONES MÉDICAS		Si	No
16.	¿Tose, sibilas o experimenta alguna dificultad para respirar durante o después de hacer ejercicio?		
17.	¿Le falta un riñón, un ojo, un testículo (en el caso de los hombres), el bazo o cualquier otro órgano?		
18.	¿Sufre dolor en la ingle o en los testículos, o tiene alguna protuberancia o hernia dolorosa en la zona inguinal?		
19.	¿Padece erupciones cutáneas recurrentes o que aparecen y desaparecen, incluyendo el herpes o <i>Staphylococcus aureus</i> resistente a la meticilina (MRSA)?		

PREGUNTAS SOBRE CONDICIONES MÉDICAS (CONTINUACIÓN)		Si	No
20.	¿Alguna vez sufrió un traumatismo craneoencefálico o una lesión en la cabeza que le causó confusión, un dolor de cabeza prolongado o problemas de memoria?		
21.	¿Alguna vez sintió adormecimiento, hormigueo, debilidad en los brazos o piernas, o fue incapaz de mover los brazos o las piernas después de sufrir un golpe o una caída?		
22.	¿Alguna vez se enfermó al realizar ejercicio cuando hacía calor?		
23.	¿Usted o algún miembro de su familia tiene el rasgo drepanocítico o padece una enfermedad drepanocítica?		
24.	¿Alguna vez tuvo o tiene algún problema con sus ojos o su visión?		
25.	¿Le preocupa su peso?		
26.	¿Está tratando de bajar o subir de peso, o alguien le recomendó que baje o suba de peso?		
27.	¿Sigue alguna dieta especial o evita ciertos tipos o grupos de alimentos?		
28.	¿Alguna vez sufrió un desorden alimenticio?		
UNICAMENTE MUJERES		Si	No
29.	¿Ha tenido al menos un período menstrual?		
30.	¿A los cuántos años tuvo su primer período menstrual?		
31.	¿Cuándo fue su período menstrual más reciente?		
32.	¿Cuántos períodos menstruales ha tenido en los últimos 12 meses?		

Proporcione una explicación aquí para las preguntas en las que contestó "Sí".

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**Por la presente declaro que, según mis conocimientos, mis respuestas a las preguntas de este formulario están completas y son correctas.**

Firma del atleta: \_\_\_\_\_

Firma del padre o tutor: \_\_\_\_\_

Fecha: \_\_\_\_\_

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## ■ PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

#### PHYSICIAN REMINDERS

- 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ ( _____ / _____ )	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or <i>linea corporis</i></li> </ul>		
Neurological		
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>		

<sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, 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 further 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 preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

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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## Gfeller–Waller NCHSAA Student–Athlete & Parent/Legal Custodian Concussion Information Sheet

**What is a concussion?** A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

**How do I know if I have a concussion?** There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Headache	Irritability-things bother you more easily	Sleeping more than usual
Taking longer to figure things out	Fuzzy or blurry vision	Sadness	Sleeping less than usual
Difficulty concentrating	Feeling sick to your stomach/queasy	Being more moody	Trouble falling asleep
Difficulty remembering new information	Vomiting/throwing up	Feeling nervous or worried	Feeling tired
	Dizziness	Crying more	
	Balance problems		
	Sensitivity to noise or light		

*Table is adapted from the Centers for Disease Control and Prevention (<http://www.cdc.gov/concussion/>)*

**What should I do if I think I have a concussion?** If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

**When should I be particularly concerned?** If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

**What are some of the problems that may affect me after a concussion?** You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur. Once you have a concussion, you are more likely to have another concussion.

**How do I know when it's ok to return to physical activity and my sport after a concussion?** After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

***You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign your brain has not recovered from the injury.***

*This information is provided to you by the UNC Matthew Gfeller Sport–Related TBI Research Center, North Carolina Medical Society, North Carolina Athletic Trainers' Association, Brain Injury Association of North Carolina, North Carolina Neuropsychological Society, and North Carolina High School Athletic Association.*

# Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Statement Form

Instructions: The student athlete and his/her parent or legal custodian, must initial beside each statement acknowledging that they have read and understand the corresponding statement. The student-athlete should initial in the left column and the parent or legal custodian should initial in the right column. Some statements are applicable only to the student-athlete and should only be initialed by the student-athlete. This form must be completed for each student-athlete, even if there are multiple student-athletes in the household.

Student-Athlete Name: (please print)\_\_\_\_\_

Parent/Legal Custodian Name(s): (please print)\_\_\_\_\_

Student-  
Athlete  
Initials

Parent/Legal  
Custodian(s)  
Initials

	A concussion is a brain injury, which should be reported to my parent(s) or legal custodian(s), my or my child's coach(es), or a medical professional if one is available.	
	A concussion cannot be "seen." Some signs and symptoms might be present immediately; however, other symptoms can appear hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	Not Applicable
	If I think a teammate has a concussion, I should tell my coach(es), parent(s)/ legal custodian(s) or medical professional about the concussion.	Not Applicable
	I, or my child, will not return to play in a game or practice if a hit to my, or my child's, head or body causes any concussion-related symptoms.	
	I, or my child, will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away, right away. I realize that resolution from a concussion is a process that may require more than one medical visit.	
	I realize that ER/Urgent Care physicians will not provide clearance to return to play or practice, if seen immediately or shortly after the injury.	
	After a concussion, the brain needs time to heal. I understand that I or my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms listed on the Student-Athlete/ Parent Legal Custodian Concussion Information Sheet.	
	I have asked an adult and/or medical professional to explain any information contained in the Student-Athlete & Parent Concussion Statement Form or Information Sheet that I do not understand.	

**By signing below, we agree that we have read and understand the information contained in the Student-Athlete & Parent/Legal Custodian Concussion Statement Form, and have initialed appropriately beside each statement.**

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Custodian

\_\_\_\_\_  
Date

***This Honor Code must be initialed and signed before a student may dress and/or compete in an athletic contest.***

**STUDENT'S NAME** (print): \_\_\_\_\_

**SCHOOL (print):** \_\_\_\_\_ **SPORT:** \_\_\_\_\_ **GRADE:** \_\_\_\_\_

**PARENT/ LEGAL CUSTODIAN/ LEGAL GUARDIAN/ HARDSHIP CAREGIVER NAME (print):** \_\_\_\_\_

**STUDENT'S DOMICILE (print):** \_\_\_\_\_

Number & Street	City/Town, State	Zip Code

I understand the eligibility requirements for the student named on the Honor Code to take part in interscholastic athletics in Charlotte-Mecklenburg Schools. If I had questions, the school athletic director answered them prior to my initialing/signing the Honor Code.

My initials and signature acknowledge that:

<b>Student-Athlete Initials</b>		<b>Parent, Legal Custodian, Legal Guardian or Hardship Caregiver Initials</b>
N/A	I am the parent, legal custodian or legal guardian of the student named above or I have been designated as the Hardship Caregiver by the CMS Student Placement Office.	
	ALL information I am providing on this Honor Code is the truth. My correct and current address is provided above. I understand that lying is cheating.	
	The address listed on this form, and provided to the school registrar & school athletic director where the student is enrolled, is where I actually live at the present time.	
	I currently live in the attendance area for the school listed on this Honor Code, or the student was assigned to the school listed on the Honor Code through the student assignment lottery, or the student received a transfer to the school.	
	I am not aware of any other students or parents who have given false information to CMS so they can participate on an athletic team.	
	I will immediately report all suspected athletic eligibility violations to the principal or athletic director at the school listed on this honor code.	
	I am aware that if I provide false information concerning athletic eligibility to the school and/or do not report information about known athletic eligibility falsifications of others that I may be penalized by the North Carolina High School Athletic Association (high school only) and by Charlotte-Mecklenburg Schools. I may lose the privilege of participation in athletics for 365 days and my team may have to forfeit contests.	N/A
N/A	I am aware that if I provide false information concerning athletic eligibility; do not report information about known athletic eligibility falsifications of others; and/or do not update my home address with the school registrar and athletic director the student-athlete listed above and his or her athletic team may be penalized by the North Carolina High School Athletic Association (high school only) and by Charlotte-Mecklenburg Schools, including losing the privilege of participation in athletics for 365 days and the team may have to forfeit contests.	

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Signature of Student Listed Above

Date \_\_\_\_\_

Signature of Parent, Legal Custodian, Legal Guardian or Hardship Caregiver Listed Above

Date \_\_\_\_\_

## NOTICE AND RELEASE

**IMPORTANT:**        **THIS NOTICE AND RELEASE MUST BE SIGNED AND RETURNED BEFORE YOUR STUDENT-ATHLETE CAN PARTICIPATE IN THE MIDDLE SCHOOL FOOTBALL PROGRAM.**

**To:**                      Parents of students interested in participating in the Middle School Football Program

**Subject:**                Student Accident Insurance – Middle School Football

**Please read this Notice and Release carefully and make sure that you understand its provisions before deciding whether to permit your student-athlete to participate in the Middle School Football Program.**

1.        The Charlotte-Mecklenburg School System provides accident insurance in the amount of \$25,000 at no charge for all students participating in the Middle School Football Program. **The Middle School Football accident insurance benefits provided by the school system will pay only toward those covered expenses in excess of expenses recoverable from other insurance.** This means that any applicable personal insurance that you may carry would apply first, and the Middle School Football Accident Insurance would apply only to those covered expenses not paid by your other insurance. If you do not have other insurance, the Middle School Football Accident Insurance will pay toward covered expenses up to \$25,000.
2.        There are limitations under the Middle School Football Accident Insurance coverage. **It will not always pay all of the charges incurred for every accident.** This insurance only provides certain benefits for injury or loss due to practicing and playing in the Middle School Football program. For a summary of the coverage benefits, please refer to the Student Accident Insurance Information (for Middle School Football) that has been furnished to each student interested in participating in the Middle School Football Program. If you did not receive the information or if you have questions about the insurance coverage provided to participants in the Middle School Football Program, contact the Athletic Director/Coach where your student-athlete is enrolled.
3.        Every player is required by the National Federation of State High School Athletic Associations (NFSHSAA) regulations to wear a mouth guard. An additional \$150.00 per sound natural tooth is available for any player who sustains injuries to their teeth as a result of the failure of the mouth guard, provided that they were wearing the required mouth guard at the time of the injury.

**PLEASE COMPLETE THE BACK OF THE FORM**



## MIDDLE SCHOOL FOOTBALL ONLY

## GREEN FORM

4. To be eligible for practice or participation in the Middle School Football Program, each participant must receive an **ANNUAL MEDICAL EXAMINATION** and return a physical examination form each calendar year (every 395 days) signed by a physician licensed to practice medicine.
5. Neither the Board of Education nor any of its employees assumes any responsibility for claims resulting from injury to your Student Athlete while they are participating in the Middle School Football Program. This means that you will have to pay for any medical expenses not covered by the Middle School Football Accident Insurance, any personal insurance coverage that you might have and/or any other applicable insurance.

I, \_\_\_\_\_, (print name) hereby state that I have read and understand the provisions of this Notice and Release as well as the Student Accident Insurance information for the Middle School Football Accident Insurance coverage. I also state that prior to signing this document, I have had an opportunity to ask questions and that my questions have been answered to my satisfaction. I acknowledge that neither the Board of Education nor any of its employees assumes any responsibility for claims resulting from injury to my Student-Athlete while they are participating in the Middle School Football Program. In consideration of my Student-Athlete being permitted to participate in the Middle School Football Program, I **hereby waive, release, and forever discharge** the Charlotte-Mecklenburg Board of Education and its employees from any responsibility for claims resulting from injuries to my Student-Athlete due to their participation in the Middle School Football Program. I also state that my Student-Athlete has received a Medical Examination and has returned a physical examination form in compliance with the policy set forth in paragraph 4 of this Notice and Release. I certify that I consent to have my Student-Athlete participate in the Middle School Football Program offered at their school.

**SIGNED: (Parent or Legal Guardian)** \_\_\_\_\_ **Date** \_\_\_\_\_

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

**Student's Full Name:** \_\_\_\_\_

**School:** \_\_\_\_\_

NOTICE AND RELEASE

**IMPORTANT:**        **THIS NOTICE AND RELEASE MUST BE SIGNED AND RETURNED BEFORE YOUR SON/DAUGHTER CAN PARTICIPATE IN THIS PROGRAM.**

**TO:**                      Parents of students interested in participating in Athletics

**SUBJECT:**             Student Accident Insurance for Athletics

**SPORT (S):**           \_\_\_\_\_

**Please read this Notice and Release carefully and make sure that you understand its provisions before deciding whether to permit your son or daughter to participate in middle or senior high athletics.**

1.     Board of Education policy requires that the Student Accident Insurance offered by the school system, will be required for all students participating in middle and senior high school athletics unless an insurance waiver form is signed by the parent indicating adequate personal insurance and releasing the Board of Education and its employees from responsibility for any claim due to injuries received while participating in a school sponsored athletic program.
2.     There are limitations in the Student Accident Insurance coverage. **IT WILL NOT ALWAYS PAY ALL OF THE CHARGES INCURRED FOR EVERY ACCIDENT.** For a summary of the coverage and benefits provided by the Student Accident Insurance, please read the current Student Accident Insurance Brochure that was furnished to each student at the beginning of the school year. If you did not receive the brochure or if you have questions about the insurance coverage provided under the policy, contact the Athletic Director at the school where your son/daughter is enrolled.
3.     To be eligible for practice or participation in any school athletic program, each participant must receive an **ANNUAL MEDICAL EXAMINATION** and return a physical examination form each calendar year (every 395 days) signed by a physician licensed to practice medicine.
4.     Neither the Board of Education nor any of its employees assumes any responsibility for claims resulting from injury to your son/daughter while he or she is participating in the school athletic program. This means that you will have to pay for any medical expenses not covered by the Student Accident Insurance, any personal insurance coverage that you might have and/or any other applicable insurance.

I, \_\_\_\_\_, (print name) hereby state that I have read and understand the provisions of this Notice and Release as well as the Student Accident Insurance Brochure. I further state that prior to signing this document, I have had an opportunity to ask questions and that my questions have been answered to my satisfaction. I acknowledge that neither the Board of Education nor any of its employees assumes any responsibility for claims resulting from injury to my son/daughter while he or she is participating in the school athletic program. **I HEREBY WAIVE, RELEASE, AND DISCHARGE** the Charlotte-Mecklenburg Board of Education and its employees from any responsibility for claims resulting from injuries to my son/daughter due to his or her participation in this athletic program. I hereby certify that my son/daughter has received a MEDICAL EXAMINATION and has returned a physical examination form in compliance with the policy set forth in paragraph 3 of this Notice and Release. I certify that I consent to have my son/daughter participate in school athletic activity as identified on this Notice and Release. I make the following representation and selection (check one, sign and return promptly):

\_\_\_\_\_ I have adequate personal insurance that will cover injuries that might be sustained by my son/daughter as a result of his/her participation in the school athletics. I understand that in the event my son/daughter sustains any injuries as a result of his/her participation in school athletics, I am responsible for payment of medical expenses or other items not covered by any personal insurance.

\_\_\_\_\_ My son/daughter has enrolled in the Student Accident Insurance Program on \_\_\_\_/\_\_\_\_/\_\_\_\_, and I understand that in the event my son/daughter sustains any injuries as a result of his/her participation in school athletics, I am responsible for payment of any medical expenses or other items not covered by the Student Accident Insurance.

**SIGNED: (Parent or Legal Guardian)** \_\_\_\_\_ **Date** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**STUDENT'S FULL NAME:** \_\_\_\_\_

**SCHOOL:** \_\_\_\_\_

## Charlotte-Mecklenburg Schools

### Application for Waiver of Athletic Participation Fee

## Student-Athlete & Parent/Guardian Confirmation of Signed Athletic Eligibility Forms

My signature below confirms I read, understand and completed in full the on-line athletic eligibility forms noted below. In addition, I emailed the documents \_\_\_\_\_  
(file name)

to \_\_\_\_\_ on \_\_\_\_\_  
(school athletic director) (date)

My signature also confirms the information I provided on all athletic eligibility forms is accurate and truthful. I understand false and/or inaccurate information may result in a 365-day athletic ineligibility period for the student-athlete who signs below. **I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature and by typing my name in the packet; I am electronically signing those documents.**

**Student-Athlete Signature** \_\_\_\_\_ Date \_\_\_\_\_

*Print Name* \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ Date \_\_\_\_\_

*Print Name* \_\_\_\_\_

### Athletic Forms Package

*(Initial all forms submitted or printed)*

- \_\_\_\_ CMS Middle School Student-Athlete Pre-Participation Form
- \_\_\_\_ NCHSAA MS Pre-Participation Physical Evaluation
- \_\_\_\_ NCHSAA MS Pre-Participation Physical Evaluation (Spanish)!
- \_\_\_\_ Concussion Statement Form Student/Parent
- \_\_\_\_ Athletic Honor Code Form Student/Parent
- \_\_\_\_ 2021-22 Football Insurance-Green Form
- \_\_\_\_ 2021-22 All Other Sports Insurance-Blue Form
- \_\_\_\_ Athletic Participation Fee Waiver Application (if Applicable)  
(Print & complete this form and hand deliver to AD)
- \_\_\_\_ Confirmation of Signed Eligibility Forms  
(Print & complete this form and hand deliver to AD)