

**ARENDELL PARROTT ACADEMY
KINSTON NC
ATHLETIC HEALTH FORM**

SECTION I:

LAST NAME: _____ FIRST _____ MIDDLE _____

SPORTS: (1) _____ (2) _____ (3) _____

GRADE _____ DATE OF BIRTH _____ AGE _____ GENDER _____

HEIGHT _____ (inches) WEIGHT _____ (lbs) BP _____ / _____ Pulse _____ /min

CORRECTED VISION: HEARING (gross)
 Right 20/ _____ Left 20/ _____ Right _____ Left _____

URINE: (multistix)

ARE THERE ABNORMALITIES OF THE FOLLOWING SYSTEMS? DESCRIBE FULLY. USE ADDITIONAL SHEET IF NECESSARY.

	YES	NO
1. Head, Ears, Nose or Throat		
2. Eyes		
3. Respiratory		
4. Cardiovascular		
5. Gastrointestinal		
6. Hernia		
7. Musculoskeletal		
8. Metabolic/Endocrine		
9. Neuropsychiatric		
10. Skin		

- A. Is there any loss of or severely impaired function of any organ? _____
- B. Is athlete currently under treatment for any medical or emotional condition? _____
- C. Any recommendations or general comments regarding athlete's physical activity or the care of this athlete: _____

- D. Any known activity restrictions: _____

PHYSICIANS SIGNATURE: _____ EXAMINATION DATE: _____

PHYSICIANS PRINTED NAME: _____
 ADDRESS _____ TELEPHONE _____

SECTION II:

ATHLETE'S DIRECTIONS: Please review all questions with your parent or guardian. Provide answers to the best of your knowledge.

PHYSICIAN'S DIRECTIONS: It is recommended repeating the questions listed below, carefully reviewing details of any positive responses.

		DON'T
YES	NO	KNOW

1. Has anyone in the athlete's family (grandparent, parent, sibling, etc) died suddenly before age 50?
2. Has the athlete ever stopped exercising due to dizziness or passed out or passed out while exercising?
3. Does the athlete have asthma, hay fever or coughing after exercise?
4. Has the athlete ever had a broken bone, had to wear a cast or had a joint injury?
5. Does the athlete have a history of a concussion?
6. Has the athlete suffered a heat-related reaction or illness (heat stroke)?
7. Does the athlete have anything he/she wishes to discuss with his/her physician?
8. Does the athlete have a chronic illness or see a physician regularly for any condition?
9. Does the athlete take any medications?
10. Is the athlete allergic to any medications or bee stings?
11. Does the athlete have only one of any paired organs (eyes, ears, kidneys, testicles, ovaries, etc.)?

Please elaborate on any positive answers above: _____

PARENTAL PERMISSION FOR MEDICAL TREATMENT	
ATHLETE: _____	
ADDRESS _____	CITY _____ NC ZIP _____
NOTIFY IN CASE OF EMERGENCY _____	RELATION _____
HOME PHONE _____	OFFICE _____ CELL _____
INSURANCE PROVIDER _____	POLICY # _____
(please attach copy of current insurance card)	
HAVE YOU PURCHASED STUDENT ACCIDENT INSURANCE? _____	
<p>I have answered and reviewed the above questions and give parental permission for my child to participate in the sports program of Arendell Parrott Academy. In the event of an emergency requiring medical attention, I hereby grant permission for a physician, nurse, athletic trainer and/or coach, or any hospital personnel to attend to my son/daughter.</p>	
SIGNED: _____	DATE: _____
PRINTED NAME OF SIGNATURE ABOVE: _____	