**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.***

| YES | NO | DON'T 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? __________________**

**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.**

**SIGNED: ______________________________________________ DATE: ____________________________**

**PRINTED NAME OF SIGNATURE ABOVE: ______________________________________________________**