Elkin High School
334 Elk Spur St. • Elkin, North Carolina 28621
Phone 336-835-3858 • Fax 336-835-3253

Dear Parent:

Please read the following and return with your child's application to participate in sports.

The Elkin Board of Education provides all sports accident insurance coverage at no cost to all students participating in sports. This insurance is an excess cost benefit program. Excess cost benefit programs pay only after other insurance such as a family health plan have paid. However, if the student has no other insurance coverage, the excess benefit program would pay 100% of the **allowable** charges.

If you choose to cover your child with student accident insurance (school-time or 24-hour coverage), please be aware that state law prohibits the same insurance company from paying double benefits on the same accident. For example: If you purchase student insurance coverage for your child and your child is hurt while participating in a sport, the all sports coverage provided by the Board of Education will pay benefits on the injury, but the student insurance will not because the insurance is provided by the same company.

Please follow these guidelines if your child is injured while participating in a sport.

1. Make sure the hospital and/or doctor is made aware of your personal insurance coverage as well as the coverage under the all sports plan provided by the Board of Education.

2. Immediately notify the Secretary/Treasurer at Elkin High School that your child was injured. Make sure that you give complete information regarding the accident.

3. As soon as you receive a statement from your personal insurance company regarding the benefits paid, forward a copy of the statement and a copy of the charges (doctor, hospital, etc.) to the Secretary/Treasurer at Elkin High School. If your child has no personal insurance, forward a copy of the charges (doctor, hospital, etc.) to the Secretary/Treasurer at Elkin High School immediately upon receipt,

4. If you have not heard from the all sports insurance company within 30 days of sending the above to the Secretary/Treasurer at Elkin High School, please call the Secretary/Treasurer to check the status of your claim.

A copy of the benefit coverage for the all sports plan is attached for your convenience.

I have read the above information concerning insurance coverage for my child.
My child_____
(child's name)
does_____, does not_____have personal insurance coverage.

_____
Parent's Signature Date

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ATHLETIC ELIGIBILITY REQUIREMENTS FOR ELKIN HIGH SCHOOL STUDENTS

1. Athletes must reside in the Elkin City Schools district or be officially released from the Surry, Wilkes or Yadkin County Schools.

2. Athletes must have been in attendance for at least 85% of the previous semester.

3. Athletes must pass 3 out of 4 courses during the preceding semester and meet local promotion standards.

4. Athletes must pass a medical examination once every 365 days by a licensed medical doctor.

5. Athletes, upon first entering grade 9 are eligible for 8 consecutive semesters.

6. No student may be approved for any athletic contest if his/her 19th birthday comes before October 16, 1998.

7. A player shall not dress for a game or scrimmage when he/she is not eligible to participate in the game. Ineligible players are not allowed to participate in practice at any time.

NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION
SPORT PREPARTICIPATION EXAMINATION FORM

Patient's Name: _____ **Age:** _____ **Sex:** _____

This is a screening examination for participation in sports. This does not substitute for a comprehensive examination with your child's regular physician where important preventive health information can be covered.

Athlete's Directions: Please review all questions with your parent or legal custodian and answer them to the best of your knowledge.

Parent's Directions: Please assure that all questions are answered to the best of your knowledge. If you do not understand or don't know the answer to a question please ask your doctor. Not disclosing accurate information may put your child at risk during sports activity.

Physician's Directions: We recommend carefully reviewing these questions and clarifying any positive or Don't Know answers.

Explain "Yes" answers below	Yes	No	Don't know
1. Does the athlete have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, etc.]? List:	❑	❑	❑
2. Is the athlete presently taking any medications or pills?	❑	❑	❑
3. Does the athlete have any allergies (medicine, bees or other stinging insects, latex)?	❑	❑	❑
4. Does the athlete have the sickle cell trait?	❑	❑	❑
5. Has the athlete ever had a head injury, been knocked out, or had a concussion?	❑	❑	❑
6. Has the athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	❑	❑	❑
7. Has the athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	❑	❑	❑
8. Has the athlete ever fainted or passed out AFTER exercise?	❑	❑	❑
9. Has the athlete had extreme fatigue (been really tired) with exercise (different from other children)?	❑	❑	❑
10. Has the athlete ever had trouble breathing during exercise, or a cough with exercise?	❑	❑	❑
11. Has the athlete ever been diagnosed with exercise-induced asthma ?	❑	❑	❑
12. Has a doctor ever told the athlete that they have high blood pressure?	❑	❑	❑
13. Has a doctor ever told the athlete that they have a heart infection?	❑	❑	❑
14. Has a doctor ever ordered an EKG or other test for the athlete's heart, or has the athlete ever been told they have a murmur?	❑	❑	❑
15. Has the athlete ever had discomfort, pain, or pressure in his chest during or after exercise or complained of their heart "racing" or "skipping beats"?	❑	❑	❑
16. Has the athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	❑	❑	❑
17. Has the athlete ever had a stinger, burner or pinched nerve?	❑	❑	❑
18. Has the athlete ever had any problems with their eyes or vision?	❑	❑	❑
19. Has the athlete ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints?	❑	❑	❑
❑ Head ❑ Shoulder ❑ Thigh ❑ Neck ❑ Elbow ❑ Knee ❑ Chest ❑ Hip ❑ Forearm ❑ Shin/calf ❑ Back ❑ Wrist ❑ Ankle ❑ Hand ❑ Foot			
20. Has the athlete ever had an eating disorder, or do you have any concerns about your eating habits or weight?	❑	❑	❑
21. Has the athlete ever been hospitalized or had surgery?	❑	❑	❑
22. Has the athlete had a medical problem or injury since their last evaluation?	❑	❑	❑
FAMILY HISTORY	❑	❑	❑
23. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?	❑	❑	❑
24. Has any family member had unexplained heart attacks, fainting or seizures?	❑	❑	❑
25. Does the athlete have a father, mother or brother with sickle cell disease?	❑	❑	❑

Elaborate on any positive (yes) answers: _____

_____

_____

_____

By signing below I agree that I have reviewed and answered each question above. Every question is answered completely and is correct to the best of my knowledge. Furthermore, I give permission for my child to participate in sports.

Signature of parent/legal custodian: _____ Date: _____

Signature of Athlete: _____ Date: _____ Phone #: _____

Physical Examination (Must be Completed by a Licensed Physician, Nurse Practitioner or Physician Assistant)

Athlete's Name_____ Age_____ Date of Birth _____

Height_____ Weight_____ BP _____(____% ile) / _____(____% ile) Pulse____

Vision R 20/_____ L 20/_____ Corrected: Y N

These are required elements for all examinations			
	NORMAL	ABNORMAL	ABNORMAL FINDINGS
PULSES			
HEART			
LUNGS			
SKIN			
NECK/BACK			
SHOULDER			
KNEE			
ANKLE/FOOT			
Other Orthopedic Problems			

Optional Examination Elements – Should be done if history indicates

HEENT			
ABDOMINAL			
GENITALIA (MALES)			
HERNIA (MALES)			

Clearance**:

- ☐ A. Cleared
- ☐ B. Cleared after completing evaluation/rehabilitation for :_____
- ☐ C. Not cleared for: ☐ Collision ☐ Contact
  ☐ Non-contact _____Strenuous _____Moderately strenuous _____Non-strenuous

Due to:_____

_____

_____

Additional Recommendations/Rehab Instructions:_____

_____

_____

_____

_____

_____

Name of Physician/Extender:_____

Signature of Physician/Extender_____ MD DO PA NP

(Signature and circle of designated degree required)

Date of exam:_____

Address: _____

_____

Phone_____

Physician Office Stamp:

(** The following are considered disqualifying until appropriate medical and parental releases are obtained: post-operative clearance, acute infections, obvious growth retardation, diabetes, jaundice, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, a chronic musculoskeletal condition that limits ability for safe exercise/sport (i.e. Klippel-Feil anomaly, Sprengel's deformity), history of convulsions or concussions, absence of/ or one kidney, eye, testicle or ovary, etc.)

This form approved by the North Carolina High School Athletic Association Sports Medicine Advisory Committee March 2011, and the NCHSAA Board of Directors reviewed annually.