NC TARHEEL CHALLENGE ACADEMY
GENERAL HEALTH EXAMINATION FORM

Candidate's Name: _____ Age: _____ Sex: _____

This is a screening examination for mental and/or physical health. <u>This does not substitute for a comprehensive examination</u> with your child's regular physician where important preventive health information can be covered.

<u>Candidate's Directions:</u> Please review all questions with your parent/legal guardian and answer them to the best of your knowledge.

<u>Parent/Guardian's Directions</u>: 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 participation with the Academy.

<u>Physician's Directions:</u> We recommend carefully reviewing these questions and clarifying any ***YES*** or ***UNSURE*** answers.

EXPLAIN "YES" ANSWERS BELOW	**YES**	**DATE**	**NO**	**UNSURE**
1. Does the candidate have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, etc.] LIST:				
2. Is the candidate presently taking any medications or pills?				
3. Does the candidate have any allergies (medicine, bees or other stinging insects, latex, food)?				
4. Has the candidate ever had a head injury, been knocked out, or had a concussion?				
5.Has the candidate ever had a heat injury (heat stroke) or sever muscle cramps with activities?				
6. Has the candidate ever passed out or nearly passed out DURING exercise, emotion or startle?				
7.Has the candidate ever passed out AFTER exercise?				
8. Has the candidate had extreme fatigue (been really tired) with exercise (different from other youth)?				
9. Has the candidate ever had trouble breathing during exercise, or a cough with exercise?				
10. Has the candidate ever been diagnosed with exercise-induced asthma?				
11. Has a doctor ever told the candidate that he/she has high blood pressure?				
12. Has a doctor ever told the candidate that he/she have a heart infection?				
13. Has a doctor ever ordered an EKG or other test for the candidate's heart, OR has the candidate ever been told they have a heart murmur?				
14. Has the candidate ever had discomfort, pain or pressure in his/her chest during or after exercise or complained of their "racing" or "skipping beats"?				
15. Has the candidate ever had a seizure OR been diagnosed with and unexplained seizure problem?				
16. Has the candidate ever had a stinger, burner, or pinched nerve?				
17. Has the candidate ever had a problem with his/her eyes or vision?				
18. Has the candidate ever had a problem with his/her ears or hearing?				
19. Has the candidate ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injury of any bones or joints?				
O Head O Shoulder O Thigh O Neck O Elbow O Knee O Chest O Hip O Forearm O Shin/calf O Back O Wrist O Ankle O Hand O Foot				
20. Has the candidate ever had an eating disorder OR do you have any concerns about your eating habits or weight?				
21. Has the candidate ever received a PPD skin test?				
22. Has the candidate ever seen a psychiatrist, psychologist, social worker, counselor or other professional for any reason?				
23. Has the candidate ever been treated for alcohol/drug abuse or problems (to include legal or illegal drugs) or any other addiction or addictive behavior?				
24. Has the candidate ever been evaluated, treated, or recommended for treatment for depression, suicidal thoughts or attempts, self-mutilating/cutting violent behavior?				
25. Has the candidate ever been evaluated or treated for sexually transmitted infection/disease OR sexual or physical abuse?				
26. Has the candidate ever been evaluated or treated for mood/anxiety disorders, hallucinations, paranoia, bipolar disorders?				
27. Has the candidate ever been evaluated or treated for attention/behavior disorders OR physical performance?				
FAMILY HISTORY				
28. Has any family member had a sudden, unexpected, death before age 50 [including from Sudden Infant Death Syndrome (SIDS) OR other illness, car accident, drowning?				
29. Has any family member had unexplained heart attacks, fainting or seizures?				
30. Does the candidate have a father, mother, or brother with sickle cell disease?				

Explain any *YES* or *UNSURE* answers: _____

_____

_____

_____

By signing below I agree that I have reviewed and answered each question on the front page. Every question is answered completely and is correct to the best of my knowledge. Furthermore, as parent/guardian, I give consent for this examination and give permission for my youth to participate the Academy.

Parent/Guardian Signature: _____ Date: _____ Phone #: _____

Candidate Signature: _____ Date: _____ Phone #: _____

Physical Examination [Must be completed by a Licensed Physician, Nurse Practitioner, or Physician Assistant]

Candidate's Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ BP: _____(_____% ile) / _____(_____% ile) Pulse: _____

Vision **R** 20/ _____ **L** 20/ _____ Corrected: Yes No

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. ***Medical Waiver Form must be attached [for the condition of: _____]**
- ○ **D. Not cleared for:** ○ **Collision** ○ **Contact**
  ○ **Non-contact** **_____ Strenuous** **_____Moderately Strenuous** **_____Non-strenuous**

Due to: _____

_____

_____

STD & PPD CHECKS (Need to be tested no more than 6 weeks prior to In-Processing): _____

_____

_____

_____

Name of Physician/Extender: _____

Physician/Extender Signature: _____ **MD DO PA NP**

[Signature and circle of designated degree required]

Date of exam: _____

Address: _____

_____

Phone: _____

Physician Office Stamp: