Student-Athlete Name:_____ Appt Time:_____

2019 Heart of a Pioneer Paperwork Packet
Saturday June 8th
Watauga High School

Student-athlete and parent/guardian must complete the following and return to appropriate personnel receive an appointment:

1. Appalachian Regional Healthcare System Health Screening Consent and Release Statement

2. NCHSAA Sport Preparticipation examination Form (Only medical history section on page 1 should be completed, page 2 will be completed by medical provider on 6/8/19 at HOP Event)

Middle School Student Athletes should obtain appointment through PE teacher (at their school), Mr. Godwin (Hardin Park), Mr. Eggers (Hardin Park), or Coach Neff (Hardin Park)

High School Student Athletes should obtain appointment at WHS front desk

HEART OF A PIONEER
HEALTH SCREENING CONSENT AND RELEASE AGREEMENT

I, the undersigned, am the parent/guardian having legal custody of the child listed below, an unemancipated minor, (my "Child"). I hereby consent to and give permission to Appalachian Regional Healthcare System, Inc. ("ARHS") to perform the following health screenings for my Child: Blood Pressure, Pulse, Height, Weight, Vision, EKG, and Sports Physical.

I UNDERSTAND AND ACKNOWLEDGE THE FOLLOWING: The data derived from the screening is to be considered as preliminary only and in no way conclusive. The screenings are not diagnostic and may occasionally miss abnormalities which more definitive tests would detect. The professionals involved do not have access to and cannot consider my Child's past medical history or certain characteristics of my Child's overall health. ARHS does not endorse or guarantee the results of such tests. No physician-patient relationship will be formed by participation in this health screening and no patient medical record will be created or maintained.

It is my choice if I wish to obtain any follow-up evaluation or care concerning any and all results detected at this health screening. I am solely responsible for obtaining appropriate medical attention and advice, if any, and may contact any health provider I wish. Neither ARHS nor any individual involved in the health screening is responsible for any necessary continuing care.

Privacy Standards: In the screening environment, because of the space limitations, there can be no guarantee that everything said during the actual screening event will be confidential. Those participants being served in surrounding stations may be able to overhear information about your Child (i.e., your screening results). If there is information being asked or being discussed about which you do not feel comfortable, you may ask any of our staff to speak with you "one-on-one" in another area. I understand that by signing this form I am agreeing to allow the ARHS's staff and volunteers to assess my child in the health screening, and discuss the immediate results, data and other healthcare, along with answering any questions that I may have. I am waiving any right to privacy of my Child's healthcare information, during the health screening event. I acknowledge that have had an opportunity to review ARHS's Notice of Privacy. If you have any questions contact Robert Johnston at 828-268-5464 or rjohnston@apprhs.org. Other than me and my Child's family physician (listed below), no other individual or agent will receive a copy of my Child's individual test/screening results without the expressed written permission from me.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS, I DESIRE TO HAVE SUCH HEALTH SCREENING PURSUANT TO THE TERMS CONTAINED HEREIN. ON BEHALF OF MYSELF AND MY MINOR CHILD, I HEREBY, RELEASE AND FOREVER DISCHARGE ARHS, ITS RESPECTIVE AFFILIATES, OFFICERS, DIRECTORS, EMPLOYEES, VOULTEERS, AND AGENTS FROM ANY AND ALL LIABILITY, CASUSES OF ACTIONS, SUITS, CLAIMS AND DEMANDS OF ANY KIND WHATSOEVER ARISING FROM OR IN ANY WAY CONNECTED WITH THE PHYSICAL ACTIVITY, OR OTHER PROCEDURES NECESSARY TO CONDUCT THIS HEALTH SCREEING, OR RESULTS THEREFORM. MY SIGNATURE BELOW INDICATES MY CONSENT FOR MY CHILD TO PATRICIATE IN THIS HEALTH SCREENING.

SIGNATURE (PARENT/GUARDIAN) DATE

NAME: (PRINTED PARENT/LEGAL GUARDIAN)

NAME: (PRINTED CHILD) CHILD'S DATE OF BIRTH

ADDRESS

PHONE

FAMILY PHYSICIAN

NORTH CAROLINA HIGH SCHOOL ATHLETIC ASSOCIATION SPORT PREPARTICIPATION EXAMINATION FORM

Student Athlete'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.

Student-Athlete's Directions: Please review all questions with your parent or legal custodian and answer them to the best of your knowledge.
Parent/Legal Custodian Directions: Please assure that all questions are answered to the best of your knowledge. If you do not understand or are unsure about 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 "Yes" or "Unsure" answers.

Explain "Yes" or "Unsure" answers in the space provided below or on an attached separate sheet if needed.	Yes	No	Unsure
1. Does the student-athlete have any chronic medical illnesses [diabetes, asthma (exercise asthma), kidney problems, etc.]? List:	❑	❑	❑
2. Is the student-athlete presently taking any medications or pills?	❑	❑	❑
3. Does the student-athlete have any allergies (medicine, bees or other stinging insects, latex)?	❑	❑	❑
4. Does the student-athlete have the sickle cell trait?	❑	❑	❑
5. Has the student-athlete ever had a head injury, been knocked out, or had a concussion?	❑	❑	❑
6. Has the student-athlete ever had a heat injury (heat stroke) or severe muscle cramps with activities?	❑	❑	❑
7. Has the student-athlete ever passed out or nearly passed out DURING exercise, emotion or startle?	❑	❑	❑
8. Has the student-athlete ever fainted or passed out AFTER exercise?	❑	❑	❑
9. Has the student-athlete had extreme fatigue (been really tired) with exercise (different from other children)?	❑	❑	❑
10. Has the student-athlete ever had trouble breathing during exercise, or a cough with exercise?	❑	❑	❑
11. Has the student-athlete ever been diagnosed with exercise-induced asthma?	❑	❑	❑
12. Has a doctor ever told the student-athlete that they have high blood pressure?	❑	❑	❑
13. Has a doctor ever told the student-athlete that they have a heart infection?	❑	❑	❑
14. Has a doctor ever ordered an EKG or other test for the student-athlete's heart, or has the athlete ever been told they have a heart murmur?	❑	❑	❑
15. Has the student-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 student-athlete ever had a seizure or been diagnosed with an unexplained seizure problem?	❑	❑	❑
17. Has the student-athlete ever had a stinger, burner or pinched nerve?	❑	❑	❑
18. Has the student-athlete ever had any problems with their eyes or vision?	❑	❑	❑
19. Place a check beside each body part that the student-athlete has ever sprained/strained, dislocated, fractured, broken had repeated swelling in or had any other type of injury to any bones or joints? ❑ Head ❑ Shoulder ❑ Thigh ❑ Neck ❑ Elbow ❑ Knee ❑ Chest ❑ Hip ❑ Forearm ❑ Shin/calf ❑ Back ❑ Wrist ❑ Ankle ❑ Hand ❑ Foot Other: _____			
20. Has the student-athlete ever had an eating disorder, or are there concerns about his/her eating habits or weight?	❑	❑	❑
21. Has the student-athlete ever been hospitalized or had surgery?	❑	❑	❑
22. Has the student-athlete had a medical problem or injury since their last evaluation?	❑	❑	❑
23. (Place a check beside each statement that applies to the student-athlete, elaborate in the space provided below). ❑ 1. Has the student-athlete had little interest or pleasure in doing things? ❑ 2. Has the student-athlete been feeling down, depressed, or hopeless for more than 2 weeks in a row? ❑ 3. Has the student-athlete been feeling bad about himself/herself that they are a failure, or let their family down? ❑ 4. Has the student-athlete had thoughts that he/she would be better off dead or hurting themselves?			
FAMILY HISTORY			
24. Has any family member had a sudden, unexpected death before age 50 (including from sudden infant death syndrome [SIDS], car accident, drowning)?	❑	❑	❑
25. Has any family member had unexplained heart attacks, fainting or seizures?	❑	❑	❑
26. Does the athlete have a father, mother or brother with sickle cell disease?	❑	❑	❑

Explain "yes" or "unsure" answers here: _____

_____

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, as parent or legal custodian, I give consent for this examination and give permission for my child to participate in sports.

Signature of parent/legal custodian: _____ Date: _____ Phone #: _____

Signature of Athlete: _____ Date: _____

(Rev. 3/2019) Approved for 2019-20 School Year

Student-Athlete's Name: _____ **Age:** _____ **Date of Birth:** _____

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

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

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

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: _____

_____

_____

Additional Recommendations/Rehab Instructions: _____

_____

_____

Name of Physician/Extender: _____ (Please print)

Signature of Physician/Extender: _____ MD DO PA NP (Please circle)

(Both signature and circle of designated degree required)

Date of Examination: _____

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, uncontrolled diabetes, severe visual or auditory impairment, pulmonary insufficiency, organic heart disease or Stage 2 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 uncontrolled seizures, absence of/ or one kidney, eye, testicle or ovary, etc.)

HEART OF A PIONEER

APPALACHIAN REGIONAL HEALTHCARE SYSTEM

BlueRidge ENERGY

Frequently Questions & Answers

Is this a physical or well-child check? Heart of a Pioneer includes a sport-specific screening that exceeds the North Carolina High School Athletic Association regulations for sports participation. Heart of a Pioneer screenings are not a physical and do not take the place of an annual well-child check or physical. Students are encouraged to get a well-check with their family doctor annually.

What if my child already has a current sports physical? Please check with your child's coach to see if his/her previous sports physical will cover for the entire school year. You may want to take advantage of this free sport-specific screening because it also offers EKG and concussion baseline screening for your child at no cost.

Why is this being offered at the end of the school year, instead of the beginning? Heart of a Pioneer is designed to provide time for a student-athlete to receive any needed medical follow-ups before summer workouts begin.

Can my son/daughter attend at any time during the day? No. Appointments are required in order to process the high volume of students. We will schedule appointments every 15 minutes. The coaching staff will work with your schedule and will announce the times for males and females and stagger the appointments to prevent delays.

What if I don't have a way to get my child to Watauga High School on the day of the event? Transportation to and from the event is the responsibility of the student and parents. However, if transportation issues prevent participation, please contact your child's coach or the school's athletic director who will work with you to try to provide alternative transportation.

What is an EKG? An EKG, or electrocardiogram, is a painless, non-invasive test which evaluates the health of your heart. It measures heart rate and electrical activity, and only takes about three minutes.

Will a diagnosis be made based on my child's screening EKG? No. Cardiologists will read the results of the screening in real-time to determine if your child may need additional follow-up. You may request that a copy of the EKG results be sent to your health care provider.

What does it mean if my child's screening indicates that further evaluation is needed? It may indicate the presence of a serious condition which requires further follow-up testing and treatment by a physician.

Will my child be prevented from participating in school-sponsored athletic events if the screening indicates that further evaluation is needed? Yes. Your child must undergo further evaluation and be cleared by a physician in order to participate.

What if I do not have a physician? Attending physicians and Appalachian Regional Healthcare System staff can assist families with finding a primary care physician and/or specialist for any follow-up testing.

How soon should I have my child see a physician? If your child's results show further evaluation is needed, you should have your child examined by your family physician within two weeks of being notified of the results of the screening. They should also not participate in physical activity until evaluated.

If my child's screening indicates the need for follow-up evaluation and testing with a physician, does that mean he/she has a life-threatening condition? Possibly. There is a chance of "false positive" findings; however, Appalachian Regional Healthcare System medical providers will provide you with information about finding appropriate follow-up care.

With whom are my child's results shared? Your child's health information is protected by the Health Insurance Portability and Accountability Act (HIPAA). Your child's health information is only shared with you and officials at school, to ensure they have received the annual required sports screening. Parents are encouraged to share with their family doctor.

What if I choose not to allow my child's information to be shared with Watauga High School? At this time, we will only screen participants who allow information to be shared with Watauga High School.

What if my child doesn't make the team? If your child has a desire to play sports at Watauga High School, he or she is eligible for Heart of a Pioneer health screening opportunities.

What if I miss my appointment or need to come at a different time? The day during which Heart of a Pioneer is conducted will be hectic and busy. It is important for students to adhere to their scheduled appointment time. If there are circumstances beyond your control, and your student misses their appointment, every effort will be made to get your student through the screening. However, there is no guarantee.

How long will Heart of a Pioneer Day last? How long will it take for the tests? Heart of a Pioneer day will begin at 8:00 am and last until approximately 4:00 pm. Your student should plan on at least two hours to complete all testing stations.

What should students wear? T-shirts and shorts are recommended. Sports bras are recommended for females-please avoid underwire bras.

What else should students do to prepare? Skin on the chest area should be clean and dry. Please do not use any lotions, creams, oils or powders on the skin of the chest the day of the screening. Wear contacts or glasses. No physical activity or energy drinks 1-2 hours prior to the screening.