

## Sports Physical Checklist 2023 – 2025

**Student (Birth) Name:** \_\_\_\_\_

**Student School ID:** \_\_\_\_\_

**All** forms must be **included, legible. and fully completed** before the physical is processed.

Physical Checklist	
Parent/Guardian Checklist	DHS (Office Use Only)
<input type="checkbox"/> FCS Athletic Participation Form ○ Must have insurance to participate (temporary insurance available)	<input type="checkbox"/>
<input type="checkbox"/> Health History Form (Date of Exam should = the Date of Exam with doctor) ○ Athletes with Special Needs (When Applicable)	<input type="checkbox"/>
<input type="checkbox"/> Physical Examination Form (Completed, signed & dated by doctor)	<input type="checkbox"/>
<input type="checkbox"/> Medical Clearance Form (Completed, signed & dated by doctor)	<input type="checkbox"/>
<input type="checkbox"/> "Blanket" Permission / Transportation Waiver Form	<input type="checkbox"/>
<input type="checkbox"/> Electronic Signature Agreement Form	<input type="checkbox"/>
<input type="checkbox"/> Consent to Treatment Form (2 pages)	<input type="checkbox"/>
<input type="checkbox"/> Authorization to Release Medical Information	<input type="checkbox"/>
<input type="checkbox"/> GHSA Sudden Cardiac Arrest Awareness Form	<input type="checkbox"/>
<input type="checkbox"/> GHSA Concussion Awareness Form	<input type="checkbox"/>
<input type="checkbox"/> GHSA Heat and Humidity Policy Form	<input type="checkbox"/>

DHS is now accepting hard copy physicals. Effective the 24-25 school year, all physicals will be required to be submitted hard copy. Submit completed sports physical to the Athletic Secretary in the Counseling Office or to the Athletic Director in Room 1009

DHS (Office Use Only)	
Verified by: _____	Physical Expiration Date: _____



# Forsyth County Physical Form

EXPIRES: \_\_\_\_\_  
OFFICE USE ONLY

## FORSYTH COUNTY SCHOOL SYSTEM ATHLETIC PARTICIPATION FORM

FORSYTH COUNTY ATHLETICS		PERMISSION FORM	
Student – Athlete: (Please Print)		Name of Parent/Guardian: (Please Print)	
Street Address:		School:	Grade: CIRCLE ONE 7 8 9 10 11 12
City:	State:	Zip:	Date of Birth: Phone: Home – Work –
<b>In the event of emergency, please give the best person and method to contact in the box provided.</b>			
Name:		Relationship:	Phone #: Alt #:
<b>Request for Permission:</b> We, the undersigned student and the student's parent/guardian, apply for permission to participate in interscholastic athletics in the following sport(s):			
<input type="checkbox"/> Baseball / Softball	<input type="checkbox"/> Cross Country	<input type="checkbox"/> Lacrosse	<input type="checkbox"/> Tennis
<input type="checkbox"/> Basketball	<input type="checkbox"/> Football	<input type="checkbox"/> Soccer	<input type="checkbox"/> Track & Field
<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Golf	<input type="checkbox"/> Swimming	<input type="checkbox"/> Wrestling
<input type="checkbox"/> Other: _____			
<b>General Requirements-</b> We have read and discussed the general requirements for athletic eligibility. We understand that additional questions or specific circumstances should be directed to our student's coach, athletic director or principal. We understand that the FC Athletic Guidelines are available through the county website for review.			
<b>Risk of Injury-</b> We acknowledge and understand that there is a risk of injury involved in athletic participation. We understand that the student-athlete will be under the supervision and direction of a FCSS athletic coach. We agree to follow the rules of the sport and the instructions of the coach in order to reduce the risk of injury to the student and other athletes. However, we acknowledge and understand that neither the coach nor FCSS can eliminate the risk of injury in sports. Injuries may and do occur. Sports injuries can be severe and in some cases may result in permanent disability or even death. We freely, knowingly, and willfully accept and assume the risk of injury that might occur from participation in athletics.			
<b>Release-</b> In consideration of FCSS allowing the student-athlete to participate in athletics, we agree to release and hold FCSS, its athletic coaches and other employees free, harmless and indemnified from and against any and all claims, suits or causes of action arising from or out of any injury that the student-athlete may suffer from participation in athletics.			
<b>Insurance-</b> FCS requires parents to provide information pertaining to medical insurance coverage for all student athletes. Parents have the option to purchase school insurance (please see school athletic director) or to maintain coverage under parental insurance provider.			
Check One: <input type="checkbox"/> School Accident Insurance <input type="checkbox"/> Name of Other Insurance Company		Policy No.	
Address:		Group No.	
<b>CERTIFICATION AND MEDICAL AUTHORIZATION.</b> We certify that all of the information provided by us on this form is correct. We agree to abide by state and local rules. If the student-athlete is injured while participating in athletics and FCSS is unable to contact the parent, we grant FCSS permission and authority to obtain necessary medical care and/or treatment for the student's injury. Treatment may include, but is not limited to first aid, CPR, medical or surgical treatment recommended by a physician. We accept the financial responsibility for such medical care or treatment.			
<b>We, the undersigned student and parent, have read this document and understand all of the expectations for athletic participation at my school.</b>			
Student:		Date:	
Parent/Guardian Signature:		Date:	



*(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)*

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

[illegible]

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		

9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
<b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>	<b>Yes</b>	<b>No</b>
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		

<b>BONE AND JOINT QUESTIONS</b>	<b>Yes</b>	<b>No</b>
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

<b>MEDICAL QUESTIONS</b>	<b>Yes</b>	<b>No</b>
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
<b>FEMALES ONLY</b>		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

[illegible]

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

# ■ PREPARTICIPATION PHYSICAL EVALUATION

## THE ATHLETE WITH SPECIAL NEEDS:

### SUPPLEMENTAL HISTORY FORM

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

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Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

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I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_



# PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

## PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use chewing tobacco, snuff, or dip?
  - Do you drink alcohol or use any other drugs?
  - Have you ever taken anabolic steroids or used any other performance supplement?
  - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
  - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP _____ / _____ ( _____ / _____ )	Pulse _____	Vision R 20/ _____	L 20/ _____
		Corrected <input type="checkbox"/> Y <input type="checkbox"/> N	
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) <sup>b</sup>			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic <sup>c</sup>			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.

<sup>c</sup>Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- ☐ Cleared for all sports without restriction
- ☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_
- ☐ Not cleared
- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports \_\_\_\_\_
- Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

# ■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name \_\_\_\_\_ Sex ☐ M ☐ F Age \_\_\_\_\_ Date of birth \_\_\_\_\_

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports \_\_\_\_\_

Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other information \_\_\_\_\_

# **“BLANKET” PERMISSION TO PARTICIPATE IN A SERIES OF SCHOOL SPONSORED FIELD TRIPS**

Sport: \_\_\_\_\_ School Year: \_\_\_\_\_ School: \_\_\_\_\_

I hereby request that \_\_\_\_\_ (Student's Name-PLEASE PRINT): be allowed to participate in athletic team, band, orchestra, chorus, and/or any series of field trips related to one particular area of study or activity. I understand that transportation may or may not be provided by the Forsyth County School District (District). In the event transportation is not provided by the District, transportation will be the parent's responsibility.

All team members will ride to an event in school provided transportation with the team. Any athlete who arranges independent transportation to an event, without permission from the coach and the Athletic Director in advance, will be ineligible to compete in that event. All team members will return to their High School in the Forsyth County provided transportation unless a Travel Release form is completed by a parent/guardian (see the head coach). Athletes will only be released to their own parent/guardian from a contest. A parent/guardian must sign out the athlete from the coach at the contest site. If a student and his/her parent makes arrangements for private transportation, they shall not hold the local school, officers, employees or agents responsible for any injury or loss.

Detailed trip information, including destination, date, time of departure, time of return, purpose, and supervision, will be given to the parents/guardians prior to each trip in the series. (Exceptions must be approved by the School Director of Athletics and Principal).

If any emergency medical procedures or treatment are required by the student during the trip, I consent to the trip supervisor(s) taking, arranging for, and consenting to the procedures or treatment in his/her or their discretion.

In consideration of FCSS allowing the student-athlete to participate in athletics, we agree to release and hold FCSS, its athletics coaches and other employees free, harmless, and indemnified from and against any and all claims, suits or causes of action arising from or out of any injury that the student-athlete may suffer from participation in athletics.

**NOTE:** This form must be signed by student if the student is 18 years of age or older.

\_\_\_\_\_  
Name of Student (PLEASE PRINT)

\_\_\_\_\_  
Signature of Student (if 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Parent/Guardian (PLEASE PRINT)

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

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## **TRANSPORTATION WAIVER**

### **THIS SECTION MUST BE COMPLETED BY THE PARENT**

\_\_\_\_\_  
*NAME OF STUDENT LISTED ABOVE*

All team members will ride to an event in school provided transportation with the team. Any athlete who arranges independent transportation to an event, without permission from the coach and the Athletic Director in advance, will be ineligible to compete in that event. All team members will return to their High School in the Forsyth County provided transportation unless a travel release form is completed by a parent/guardian. Athletes will only be released to their own parent/guardian from a contest. A parent/guardian must sign out the athlete from the coach at the contest site. If a student and his/her parent makes arrangements for private transportation, they shall not hold the local school, officers, employees or agents responsible for any injury or loss.

**TRAVEL RELEASE FORM** – I give my son/daughter permission to ride with an adult chaperone to/from an activity of Forsyth County Schools during the school year. I further understand that I am releasing the school & its staff from my responsibility for any accident that might occur. I also give permission for medical treatment should it be needed.

\_\_\_\_\_  
**PARENT / GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**



## **ELECTRONIC SIGNATURE AGREEMENT**

Athlete Name \_\_\_\_\_

By selecting the "I Accept" button and typing your name in the signature spaces provided on the following documents, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement.

By selecting "I Accept" and typing your name in the signature spaces provided on the following documents, you consent to be legally bound by this Agreement's terms and conditions.

You further agree that your use of a key pad, mouse or other device to select an item, button, icon or similar act/action, or to otherwise provide personal information via this pre-participation form, or in accessing or making any transaction regarding any agreement, acknowledgement, consent terms, disclosures or conditions constitutes your signature (hereafter referred to as "E-Signature"), acceptance or agreement as if actually signed by you in writing.

You also agree that no certification authority or other third party verification is necessary to validate your E-Signature and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting contract between you and the associated school.

You also represent that you are authorized to enter into this Agreement for all persons who are authorized to access any of your records and that such persons will be bound by the terms of this Agreement.

You further agree that each use of your E-Signature in obtaining a Pre-Participation Exam constitutes your agreement to be bound by the terms and conditions of the Release of Medical Information, Consent to Treat, and History Form as described on the following documents as they exist on the date of your E-Signature.

☐ I Accept, being the Athlete of an Adult Age or Parent/Guardian of said Athlete of Minor Age, the above statement.

Signature of Parent/Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_



## **CONSENT TO TREATMENT**

Dear Parent/Guardian:

In order to provide the best possible medical care for your child or ward (hereinafter, collectively, "child"), a medical record will be established for him/her. If your child should become injured while playing sports, this record will provide important information about him/her. Please complete and sign as indicated and return to your child's coach. Your signature serves as permission to treat your child until 18 years of age or until he/she has completed activity participation.

### **THIS INFORMATION MUST BE COMPLETED BEFORE YOUR CHILD CAN BE EVALUATED / TREATED FOR ANY INJURY THAT MAY OCCUR**

Athlete Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Athlete Address: \_\_\_\_\_  
Street City State Zip

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Guaranteed contact number - Pager, Cell Phone, etc. \_\_\_\_\_

### **INSURANCE INFORMATION**

#### **Primary:**

#### **Secondary:**

Company Name: \_\_\_\_\_ Company Name: \_\_\_\_\_

Policy and/or Group No.: \_\_\_\_\_ Policy and/or Group No.: \_\_\_\_\_

### **ALLERGIES/MEDICAL CONDITIONS**

My child's doctor is: \_\_\_\_\_

My child is currently taking the following medications: \_\_\_\_\_  
\_\_\_\_\_

My child has the following allergies or medical conditions: \_\_\_\_\_  
\_\_\_\_\_

**PARENTAL CONSENT**

The undersigned grants consent to \_\_\_\_\_, and to their respective employees, for the child listed above to receive an assessment and the treatment of any injuries he/she may suffer during the school year. Injury treatment would include the application of modalities such as cold, heat, electrical muscle stimulation and/or ultrasound if necessary, as well as therapeutic exercises, to safely speed recovery and return to activity.

**MEDICAL RELEASE**

I, the undersigned, give permission for school officials, chaperons, or representatives of \_\_\_\_\_ involved in the activity with my child to seek medical attention or render first aid if such attention is necessary in the discretion of the said person involved. In case of emergency, and when I cannot immediately be contacted, I give permission to the physician selected by the school officials to hospitalize, secure proper treatment, order injections, anesthesia, or surgery for my child.

**ACKNOWLEDGEMENT OF RISK**

Both the student and the parent/guardian should read this statement carefully. You should be aware that playing, practicing, conditioning and preparing for participation in any sport can be a dangerous activity involving risks of injury. The dangers and risks of sports participation include, but are not limited to: death, serious neck, head and/or spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, tendons, and other aspects of the body, general health and well being. Because of the dangers of participating in sports, the student should recognize the importance of following coaches' instructions regarding playing techniques, training, and other teams' rules and obey such instruction.

**ASSUMPTION OF RESPONSIBILITY**

It is my desire that my child participate in such athletic activities for which the within Consent to Treatment, Medical Release and Acknowledgement of Risk is being given by me as the parent or legal guardian of such child and as a precondition to my child's participation in such athletic activities. I fully understand the importance, consequences and affects of the within Consent to Treatment, Medical Release and Acknowledgement of Risk that I am entering into on behalf of myself and on behalf of my child, I have fully disclosed any medications, allergies or medical conditions that my child may have, and I assume full responsibility for any action taken in reliance upon the provisions hereof.

**THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ  
AND UNDERSTANDS THE ABOVE.**

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Print Parent's/Guardian's Name

\_\_\_\_\_  
STUDENT ATHLETE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Print Student Athlete's Name



# Authorization To Release Medical Information

I, \_\_\_\_\_, being the parent/legal guardian of \_\_\_\_\_ and residing at \_\_\_\_\_, do hereby authorize and consent to having \_\_\_\_\_ athletic trainers and/or consulting physician(s) provide any requested medical information to other physicians, other healthcare providers, the high school coaches or school administration, intercollegiate teams, professional teams, their scouts, recruiters, or athletic trainers which directly pertains to such child's or ward's (collectively "child") athletic participation at \_\_\_\_\_. Said Authorization To Release Medical Information will include, but is not necessarily limited to information concerning illnesses, injuries, treatments, hospitalizations, examinations, X-rays, or other forms of diagnostic testing occurring while participating in competitive athletics at said school or athletic organization, or otherwise medically related to such child.

I understand that I may revoke this Authorization by providing written notice to \_\_\_\_\_. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid. I understand that injury treatment will not be conditioned upon signing this Authorization. I also understand that I am waiving my right to privacy with regard to the medical records and patient identifiable information by authorizing the release of my information.

I understand that the release of the medical information provided for herein is being carried out with my consent the parent or legal guardian of such child, and accordingly, I assume full responsibility for any action taken in reliance upon this Authorization.

**I UNDERSTAND THAT SUCH CHILD'S MEDICAL INFORMATION IS CONFIDENTIAL AND PROTECTED BY A PHYSICIAN-PATIENT PRIVILEGE AND THAT I, AS THE PARENT OR LEGAL GUARDIAN OF SUCH CHILD, AM WAIVING THE PHYSICIAN-PATIENT PRIVILEGE TO THE FULL EXTENT PROVIDED FOR HEREIN AND AS ALLOWED BY LAW.**

\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Parent/Legal Guardian**

\_\_\_\_\_  
**Signature of Student Athlete**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Student Athlete**

# Georgia High School Association

## Student/Parent Sudden Cardiac Arrest Awareness Form

SCHOOL: \_\_\_\_\_

### 1: Learn the Early Warning Signs

If you or your child has had one or more of these signs, see your primary care physician:

- Fainting suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones
- Unusual chest pain or shortness of breath during exercise
- Family members who had sudden, unexplained and unexpected death before age 50
- Family members who have been diagnosed with a condition that can cause sudden cardiac death, such as hypertrophic cardiomyopathy (HCM) or Long QT syndrome
- A seizure suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones

### 2: Learn to Recognize Sudden Cardiac Arrest

If you see someone collapse, assume he has experienced sudden cardiac arrest and respond quickly. This victim will be unresponsive, gasping or not breathing normally, and may have some jerking (Seizure like activity). Send for help and start CPR. You cannot hurt him.

### 3: Learn Hands-Only CPR

Effective CPR saves lives by circulating blood to the brain and other vital organs until rescue teams arrive. It is one of the most important life skills you can learn – and it's easier than ever.

- Call 911 (or ask bystanders to call 911 and get an AED)
- Push hard and fast in the center of the chest. Kneel at the victim's side, place your hands on the lower half of the breastbone, one on top of the other, elbows straight and locked. Push down 2 inches, then up 2 inches, at a rate of 100 times/minute, to the beat of the song "Stayin' Alive."
- If an Automated External Defibrillator (AED) is available, open it and follow the voice prompts. It will lead you step-by-step through the process, and will never shock a victim that does not need a shock.

*By signing this sudden cardiac arrest form, I give \_\_\_\_\_ High School permission to transfer this sudden cardiac arrest form to the other sports that my child may play. I am aware of the dangers of sudden cardiac arrest and this signed sudden cardiac arrest form will represent myself and my child during the 2020-2021 school year. This form will be stored with the athletic physical form and other accompanying forms required by the \_\_\_\_\_ School System.*

**I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.**

_____ Student Name (Printed)	_____ Student Name (Signed)	_____ Date
_____ Parent Name (Printed)	_____ Parent Name (Signed)	_____ Date

(Revised: 2/20)



# Georgia High School Association

## Student/Parent Concussion Awareness Form

**SCHOOL:** \_\_\_\_\_

### **DANGERS OF CONCUSSION**

Concussions at all levels of sports have received a great deal of attention and a state law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor "ding" to the head, it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long-term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial – that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GHSA athletics. One copy needs to be returned to the school, and one retained at home.

### **COMMON SIGNS AND SYMPTOMS OF CONCUSSION**

- Headache, dizziness, poor balance, moves clumsily, reduced energy level/tiredness
- Nausea or vomiting
- Blurred vision, sensitivity to light and sounds
- Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments
- Unexplained changes in behavior and personality
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

**BY-LAW 2.68: GHSA CONCUSSION POLICY:** In accordance with Georgia law and national playing rules published by the National Federation of State High School Associations, any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion shall be immediately removed from the practice or contest and shall not return to play until an appropriate health care professional has determined that no concussion has occurred. (NOTE: An appropriate health care professional may include licensed physician (MD/DO) or another licensed individual under the supervision of a licensed physician, such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.

a) No athlete is allowed to return to a game or a practice on the same day that a concussion (a) has been diagnosed, OR (b) cannot be ruled out.

b) Any athlete diagnosed with a concussion shall be cleared medically by an appropriate health care professional prior to resuming participation in any future practice or contest. The formulation of a gradual return to play protocol shall be a part of the medical clearance.

*By signing this concussion form, I give \_\_\_\_\_ High School permission to transfer this concussion form to the other sports that my child may play. I am aware of the dangers of concussion and this signed concussion form will represent myself and my child during the 2020-2021 school year. This form will be stored with the athletic physical form and other accompanying forms required by the \_\_\_\_\_ School System.*

**I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.**

\_\_\_\_\_  
**Student Name (Printed)**

\_\_\_\_\_  
**Student Name (Signed)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent Name (Printed)**

\_\_\_\_\_  
**Parent Name (Signed)**

\_\_\_\_\_  
**Date**



## **GHSA Heat and Humidity Policy For ALL Sports**

The Georgia High School Association (GHSA) has established a Practice Policy for Heat and Humidity that provides guidelines for practices. This policy takes into account temperature, humidity and other environmental factors. Depending on conditions, practices may be unaffected, shortened or cancelled.

These guidelines are in a table below for your reference. The GHSA has also instituted Football Preseason Practice Regulations that dictate the number, length and dress for football practices. Those guidelines are also below:

**(All Sports)** must follow the statewide policy for conducting practices and voluntary conditioning workouts in all sports during times of extremely high heat and/or humidity that will be signed by each head coach at the beginning of each season and distributed to all players and their parents or guardians. The policy shall follow modified guidelines of the American College of Sports Medicine in regard to:

1. The scheduling of practices at various heat/humidity levels
2. The ratio of workout time to time allotted for rest and hydration at various heat/humidity levels
3. The heat/humidity level that will result in practice being terminated. A scientifically approved instrument that measures Wet Bulb Globe Temperature (WBGT) reading must be utilized at each practice to ensure that the written policy is being followed properly.

### **(Football Only Specifics) Preseason Practice Regulations**

Football may begin five consecutive weekdays prior to August 1st.

1. In the first five days of practice for any student, the practice shall not last longer than 2 hours, and the students shall not wear more than shorts, helmet, mouth piece, and shoes. (Note: the time for a session shall be measured from the time the players resort to the field until they leave the field.)

2. Beginning August 1st, any student may practice in full pads and may practice two times in single calendar day under the following stipulations

a. A student must have participated in five conditioning practices wearing shorts and helmet before being allowed to practice in full pads

b. If multiple workouts are held in a single day: i. No single session may last longer than 3 hours, ii. The total amount of time in the two practices shall not exceed 5 hours, iii. There must be at least a 3 –hour time of rest between session days must be followed by a single session day or a day off

c. These procedures are derived from recommendations created by the Inter - association task force for preseason secondary school athletics participants in the research paper -“Preseason Heat –Acclimatization Guidelines for Secondary School Athletics.”

This letter has been sent home so that parents and other guardians are aware of the steps being taken to protect our student-athletes when practicing in the heat and humidity. Any question should be directed to the head coach, athletic director, or athletic trainer.

**Please sign below to indicate that you have read and understand these policies.**

Players Name **(Print)**: \_\_\_\_\_ Parent\Guardian Signature: \_\_\_\_\_

Updated Date: 01/2017