

# Forsyth County Physical Form

# 2015-2016

School: \_\_\_\_\_



**“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 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.

**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	Date
Name of Parent/Guardian (PLEASE PRINT)	Signature of Parent/Guardian	Date

**FORSYTH COUNTY SCHOOL SYSTEM  
ATHLETIC PARTICIPATION FORM**

<b>FORSYTH COUNTY ATHLETICS</b>			<b>PERMISSION FORM</b>		
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 -	

~~In the event of an emergency, please give the person's name and method to contact in the box provided.~~

Name:	Relationship:	Phone #	Alt #:
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**Request for Permission:** 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"/> Gymnastics
<input type="checkbox"/> Basketball	<input type="checkbox"/> Football	<input type="checkbox"/> Soccer	<input type="checkbox"/> Track & Field	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cheerleading	<input type="checkbox"/> Golf	<input type="checkbox"/> Swimming	<input type="checkbox"/> Wrestling	

**General Requirements-** 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.

**Risk of Injury-** 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.

**Release-** 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.

**Insurance-** FCSS 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:

**CERTIFICATION AND MEDICAL AUTHORIZATION.** 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.

We, the undersigned student and parent, have read this document and understand all of the expectations for athletic participation at my school.

Student:	Date:
Parent/Guardian:	Date:

# PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(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.)

Date of Exam \_\_\_\_\_  
 Name \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies?  Yes  No If yes, please identify specific allergy below.  
 Medicines  Pollens  Food  Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
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: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
<b>HEART HEALTH QUESTIONS ABOUT YOU</b>	<b>Yes</b>	<b>No</b>	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
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: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
<b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>	<b>Yes</b>	<b>No</b>	39. Have you ever been unable to move your arms or legs after being hit or falling?		
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)?			40. Have you ever become ill while exercising in the heat?		
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?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
<b>BONE AND JOINT QUESTIONS</b>	<b>Yes</b>	<b>No</b>	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
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)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			<b>FEMALES ONLY</b>		
25. Do you have any history of juvenile arthritis or connective tissue disease?			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?		

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
MEDICAL		Vision R 20/		L 20/
		Corrected <input type="checkbox"/> Y <input type="checkbox"/> N		
		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)*				
Skin				
• HSV, lesions suggestive of MRSA, tinea corporis				
Neurologic*				
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.  
 \*Consider GI exam if in private setting. Having third party present is recommended.  
 \*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 \_\_\_\_\_

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

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# 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 \_\_\_\_\_

# 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.
- c) It is mandatory that every coach in each GHSA sport participate in a free, online course on concussion management prepared by the NFHS and available at [www.nfhslearn.com](http://www.nfhslearn.com) at least every two years – beginning with the 2013-2014 school year.
- d) Each school will be responsible for monitoring the participation of its coaches in the concussion management course, and shall keep a record of those who participate.

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

SIGNED: \_\_\_\_\_  
(Student)

\_\_\_\_\_  
(Parent or Guardian)

DATE: \_\_\_\_\_