

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 |
|---|-----|----|
| 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 <input type="checkbox"/> 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? | | |
| HEART HEALTH QUESTIONS ABOUT YOUR FAMILY | Yes | No |
| 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? | | |
| BONE AND JOINT QUESTIONS | Yes | No |
| 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? | | |

| MEDICAL QUESTIONS | Yes | No |
|---|-----|----|
| 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? | | |
| FEMALES ONLY | | |
| 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

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 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 prosthesis? | | |
| 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

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

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) ^b | | | |
| Skin • HSV, lesions suggestive of MRSA, tinea corporis | | | |
| Neurologic ^c | | | |
| 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.
^bConsider GU exam if in private setting. Having third party present is recommended.
^cConsider 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 _____

DOUGLAS COUNTY SCHOOL SYSTEM ~ RELEASE / EMERGENCY MEDICAL FORM

PLEASE READ CAREFULLY

EMERGENCY MEDICAL AUTHORIZATION

Student: _____ Home Phone: _____ Address: _____

Mother's Name: _____ Bus. Phone: _____ Father's Name: _____ Bus. Phone: _____

Family Physician: _____ Phone: _____ Dentist: _____ Phone: _____

Insurance Company: _____ Policy # _____ Group # _____

WHOM CAN WE CONTACT IF NO PARENT/GUARDIAN CAN BE REACHED TO ASSUME RESPONSIBILITY FOR THIS STUDENT?

Name: _____ Phone: _____

Activities Agreement

To insure the proper atmosphere for interscholastic competition, the participant and his/her parents or guardians must understand and cooperate in helping establish that atmosphere by adhering to all school rules and regulations. When a violation of school rules occurs proper steps will be taken. A participant may be suspended from participating in interscholastic activities or from a team for violating any of the following standards: (1) falsification of physician's signature, parent or guardian's signature, any information pertaining to school enrollment, school records, or interscholastic activity forms; (2) use of, possession of, or distribution of alcohol or tobacco; misuse of non-prescription drugs, or of controlled substances; (3) theft or destruction to property of any school or individual; (4) repeated acts of unsportsmanlike conduct; (5) failure to follow rules as set for individual activities by coaches.

A student must have his/her parent's or guardian's signed permission to participate. All athletic participation requires a physical examination with the doctor's permission to participate. The participant is required to abide by the rules and regulations of the State Board of Education, the Douglas County Board of Education, and the Georgia High School Association.

Informed Consent

We realize that such activities involve the potential for injury to our son or daughter which is inherent in all activities. We acknowledge that even with the best coaching, use of the most advanced protective equipment, and strict observance of rules, injuries to our son/daughter are still a possibility. We recognize that on rare occasions these injuries to our son/daughter can be so severe as to result in total disability, paralysis or even death.

Drug Testing Consent (High School Only)

We understand that submission to testing for the presence of drugs and alcohol is a condition of participation in privileged activities in the Douglas County School System. We further understand that refusal to take the test, failure to report for the test, or if the test establishes a violation of the drug testing policy, our son/daughter will be subject to consequences as set forth by the drug testing policy (JCDAB-R (1)).

General Release

It is anticipated that my son/daughter, while a participant in interscholastic activities in the Douglas County School System, will travel to many activities off campus. Transportation for my child to these off campus activities may be school buses, private vehicles, or alternate transportation operated by employees or agents of the School System. In consideration of their performing this valuable service for me and my child, I hereby release and discharge any and all claims and causes of action of any kind or nature which may arise out of my child's travel while at school both for myself and my minor child. It is the express intent of this release to forever hold the Douglas County School System, its agents and employees, harmless for any injuries which may occur to my child as a result of travel while he or she is in the custody of the School System.

Insurance Waiver

I fully understand that the Douglas County School System does not provide any insurance and it is my responsibility to provide insurance coverage for my son/daughter. The Douglas County School System will not assume liability for injuries incurred by my son/daughter during participation in or practice of any interscholastic activity.

A parent/guardian may elect to enroll the participant in a supplemental school insurance program which is authorized by the Douglas County School System. If you choose to purchase coverage through this plan, contact the school principal or head coach for additional information.

Authorization:

In case of an emergency or accident during any school activity involving my child, which in the opinion of school authorities present requires immediate medical or surgical attention, I authorize the school to take such emergency actions as may be deemed necessary, including the transportation of the student to a hospital or medical center and authorizing medical treatment. I hereby grant permission, also to said physician to treat said condition unless I am present and request otherwise. I assume the responsibility for any medical expenses incurred during this emergency. The coach, school, or the Douglas County School System will not be held responsible for any medical expenses.

Permission to Participate:

I have carefully read and understand each of the above section and will comply with these policies or statement. Permission is granted to my son/daughter to practice and complete in interscholastic activities.

| | | | |
|----------------------------|----------------------|-------------------|----------------------|
| Parent/ Guardian Signature | Date: ____/____/____ | Student Signature | Date: ____/____/____ |
| | Mo. Day Year | | Mo. Day Year |

DOUGLAS COUNTY SCHOOL SYSTEM CONDUCT AGREEMENT FOR ATHLETIC PARTICIPATION

Participation in athletic activities is a *privilege* in schools and *not a property right*. It is to be understood by all students, parents/guardians, and coaches that the top priority is academic progress. Everyone involved in these activities will make every effort not to interfere with that ultimate goal. The purpose of this Athlete Conduct Agreement is to establish minimum standards of behavior. Therefore, *coaches and/or administrators may establish rules and consequences that are more severe than those stated below*. Team rules must be approved by the administration of each school. As a precondition to participate in GHSA governed athletics, the student and his/her parent/guardian agree that the following rules will apply:

VIOLATIONS and CONSEQUENCES
(Violations are cumulative throughout a student's 9th-12th grade educational career)

| | VIOLATION | CONSEQUENCES |
|----|--|---|
| A. | Violation of school rules resulting in In-School Suspension (ISS) or Out-of-School Suspension (OSS) during the season. | The student may resume participation when: 1. The student is released from ISS; or 2. The student returns to school on the next school day upon completion of OSS. |
| B. | Violation of school rules resulting in assignment to alternative school | Dismissed from athletics while attending alternative school. |
| C. | Student has been criminally charged with a misdemeanor, regardless of location or time, so long as such charges are pending or conviction is had. * | 1 st Offense – School administration and the coach will meet with the student and parent/guardian and discuss consequences determined by the school, which may include suspension from athletic participation. 2 nd Offense – Suspension from athletic participation for 25 calendar days and a minimum of 10% of competition dates beginning with the date of the charges. 3 rd Offense – Suspension of 1 calendar year from athletic participation beginning with the date of the charges. 4 th Offense – Permanent suspension from athletic participation |
| D. | Student found to have been in possession of, or criminally charged with, the use/possession of alcohol, illegal drugs, unauthorized use/possession of prescription drugs or other behavior altering substances.* | 1 st Offense – Suspension from athletic participation for 25 calendar days and a minimum of 10% of competition dates beginning with the date student is found to be in possession or charged. 2 nd Offense – Suspension of 1 calendar year from athletic participation beginning with the date student is found to be in possession or charged. 3 rd Offense – Permanent suspension from athletic participation. |
| E. | Student has unresolved felony charges or felony conviction.* | 1 st Offense – Suspension for 1 calendar year from athletic participation beginning with the date of arrest. 2 nd Offense – Permanent suspension from athletic participation. |
| F. | A student who commits any of the following offenses may be suspended or permanently dismissed from a team: missing practice unless excused, truancy or skipping classes, acting in an unsportsmanlike manner when representing the school, any act at school or away from school which results in any discipline by school administration, or any act at school or away from school which in the opinion of the Principal reflects in a negative manner on the school or athletic program. | |

* If out of season, consequences will begin on the GHSA start date for the next season with which the student is affiliated

NOTE: Parent/guardian must report any criminal charge or arrest of the student and related details to school athletic director or coach within 1 week of the charge or arrest, even during school breaks. Failure to do so may result in the student being suspended from athletic participation for (1) calendar year.

APPEAL PROCEDURE- Any student and/or parent/guardian wishing to appeal an athletic suspension must submit in writing through the Principal to the Assistant Director-Student Support/Athletics the reason(s) why he/she should not be disciplined. This request will then be forwarded to the members of the review committee for their consideration. The review committee will consist of the Douglas County School System Assistant Director-Student Support/Athletics and two (2) system level administrators. Parent/guardian will be given a written statement on the decision of the committee.

Student's Signature: _____ Date: _____ Parent/Guardian Signature: _____ Date: _____

EXHIBIT Descriptor Code:

JCDAC-E(1)

Student Drug Testing

Date: 06/06/2011

DOUGLAS COUNTY SCHOOL SYSTEM

Consent to Participation – Student Drug Testing

I understand that submission to testing for the presence of drugs and alcohol is a condition of participation in privileged activities in the Douglas County School System. I further understand that if I refuse to take the test, fail to report for the test, or if the test establishes a violation of the drug testing policy, I will be subject to consequences as set forth by the drug testing policy.

By signing and dating this form, I consent to take an initial drug test, if required, and be randomly tested throughout the school year. The initial drug test, when required, is to be completed prior to the start of the privileged activity. The random testing will be done monthly throughout the school year. The selection process for random drug testing will be performed by the contracting body with the participating students being notified on the day they are to report for testing.

I hereby consent to the administration of drug tests and to the conditions listed in this consent and the accompanying general prohibitions and procedures as outlined in Policy JCDAC, JCDAC-R(1), JCDAC-E(1) of the Douglas County School System Policy Manual.

I understand that unless my parent or guardian contacts the Drug Testing Administrator after the first year, and makes a formal request to remove my name and student ID number from the testing pool, my name will automatically be reentered into the testing pool each year.

Participating Student's Name: _____

Date: _____ Signature: _____

Parent/Guardian's Name: _____

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 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: _____