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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ 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: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ 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?		
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 _____

HE0503 9-2681/0410

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

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

1. 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?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ 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[a] • 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		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]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 _____

Thomasville City Schools
Department of Athletics

ATHLETIC AGREEMENT AND PARENT/GUARDIAN FORM

This form requires the signature of both the athlete and the parent/guardian. Please read carefully before you sign.

Please check the sports the athlete plans to participate in:

☐ BASEBALL	☐ CROSS COUNTRY	☐ SOFTBALL	☐ SOCCER
☐ BASKETBALL	☐ FOOTBALL	☐ SWIMMING	☐ TRACK
☐ CHEERLEADING	☐ GOLF	☐ TENNIS	

ATHLETE PARTICIPATION AGREEMENT

Name: _____ ☐ THS ☐ MPMS

This agreement to compete in interscholastic athletics is voluntary on my part. I am aware that playing or practicing to play/participate in any sport can be dangerous in nature involving ***many risks of injury***.

Because of the dangers in participating in sports, I recognize the importance of following the coaches ' instructions regarding playing techniques, training and other team rules, etc., and agree to obey such instructions.

In consideration of the Thomasville City School System Athletic Department permitting me to try out and to engage in all activities related to the team, including, but not limited to, trying out, practicing or playing/participating in that sport, I hereby assume all the risks associated with participation and agree to hold the Thomasville City School System, its Athletic Department, its employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of actions, debts, claims, or demands of any activities related to the sports participated in. The terms hereof shall serve as a release and assumption of risk for my heirs, estate, executor, administrator, and for all members of my family.

I will adhere to the rules and regulations set forth by the Georgia High School Association, the Thomasville City Board of Education, the school and the Athletic Department. Furthermore, I understand that I will be held responsible for athletic equipment issued to me. I recognize that it is a privilege to compete in athletics and will strive to earn respect for family, school, community, and myself.

_____ _____
Signature of Athlete Signature of Parent/Guardian

_____ _____
Date Date

Thomasville City Schools
Department of Athletics

PARENT/GUARDIAN AGREEMENT FORM

Dear Parent or Guardian,

Your son/daughter is a candidate for one of the athletic teams sponsored by the Thomasville City School System Athletic Department.

Participation in all athletic activities is voluntary; therefore, we would like to have your approval before your child participates in their first practice session. In addition to your permission, it is necessary for your son/daughter to have a physical examination before participation.

Realizing that participation in athletics involves the potential for injury that is inherent in all sports, I hereby give my consent for _____:

Name of Athlete

- **To represent the school in the athletic activities he/she has chosen**
- **To accompany any school team of which he/she is a member on any of its local or out-of- town trips.**

I hereby assume all the risks of my son/daughter associated with participation and agree to hold the Thomasville City School System, its Athletic Department, its employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of any kind and nature whatsoever which may arise by or in connection with his/her participation in any activities related to the Thomasville City School System Athletic Department.

The terms hereof shall serve as a release and assumption of risk for my son's/daughter's heirs, estate, executor, administrator, assignees, and for all members of his/her family.

I acknowledge that I have read and understand the above presented herein and by signing below that I am giving my permission for _____ to participate in athletics in the Thomasville City School System.

_____ _____

Signature of Parent/Guardian **Date**

Thomasville City Schools
Department of Athletics

EMERGENCY MEDICAL CONSENT FORM

Dear Parent/Guardian,

The following is an emergency medical release form for your son/daughter. This ensures fast medical treatment in the event he/she is injured and you are not available to give the doctor or hospital permission to treat your child.

ATHLETE'S NAME:

I, _____ having legal custody of _____,
(Parent/Guardian) (Athlete)

Born on _____, who resides with me at _____
(Birth Date) (Address)

_____
(City/Zip)

hereby authorize any employee with the Thomasville City School System in whose care the minor child has been entrusted to consent to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations and immunizations for the above named athlete. In the event of serious illnesses, the need for major surgery, or significant accidental injury, I understand that every possible attempt will be made by the attending physician to contact me in the
most expeditious way. In the event all reasonable attempts to contact me at the following phone numbers are unsuccessful:

- Home Phone#: _____ Cell Phone#: _____
- Work Phone#: _____ Other Phone#: _____

the treatment necessary for the interest of the above named athlete may be given. In the event that an emergency arises during a practice session, every effort will be made to contact the parents or guardians as soon as possible. Permission is also granted to the coach or athletic trainer to provide the needed emergency treatment to the athlete prior to his/her admission to the medical facilities.

- List any restrictions to your authorization to treat:

  _____

  _____

- Date athlete received last Tetanus/Diphtheria Booster:_____
- List any allergies to drug(s) or food(s) athlete may have:

  _____

- Any medication(s) or other pertinent information on athlete:

  _____

- Name of Family Physician: _____ Phone # _____

_____ _____
Date **Signature of Parent/Guardian**

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: _____

THOMASVILLE CITY SCHOOLS
CONSENT TRAVEL RELEASE FORM

This is to certify that _____ has my permission to ride (to – from - both) the
(Student"s Name) (**Circle One**)

_____ athletic contest on _____, at _____ _____.
(**Sport**) (**Date**) (**Location of Contest**)

I certify that I am personally transporting the above-named student, or have arranged for transportation with an adult (non-student) of my choosing for this student.

The reason for not riding the bus is

_____

(Reason must be sufficiently urgent to family needs to justify not riding the bus.)

I understand that the Thomasville City School's Athletic Department rules require students to ride the buses to and from all athletic events and departure from this requirement will release the Thomasville City Schools.

I agree to release the Thomasville City Schools and its employees and officers from all liability with reference to the above-stated transportation.

This form must be on file in the Athletic Director's Office prior to the dismissal of school on the day on the contest.

_____ _____
Parent's/Guardian's Signature Date

_____ _____
Student-Athlete's Signature Date

_____ _____
Coach's Signature Date

Thomasville City Schools

Department of Athletics

INSURANCE INFORMATION

- The Thomasville City School System's Athletic Department with an EXCESS INSURANCE POLICY will cover all athletes in grades 6-12 participating in interscholastic sports.

- This excess coverage is designed to consider balances only after all of the parent's/guardian's other and collectible insurances have paid their maximum benefits first. In other words, this excess policy means that your personal insurance will be liable first for any injuries incurred. Once the primary insurance has paid, then the Athletic Department's insurance will go into effect **(covering at least 80% of the cost).**

- It should be understood that this is an accident insurance policy. This policy does not pay for treatment rendered due to an illness, diseases, and degenerative injuries, conditions caused by continued stress to a particular area of the body, and existing conditions aggravated or exacerbated by an accident. Pre-existing injuries are not covered.

- In the event a player is injured, the Director of Sports Medicine will fill out the top portion of the claim form and the parents will need to fill out the bottom portion of the claim form. The claim form will then need to be filled out by the physician treating the athlete.

- The coaching staff can assure each parent that the utmost care will be taken at all times and that we hope and work toward the end that there will be no accidents.

I hereby acknowledge that I have read the above and understand the coverage described.

Athlete's Name: _____

☐ I **do** have health insurance coverage with (Please attach a copy of your insurance card)

_____ _____

Insurance Company Policy Number

☐ I **do not** have health insurance coverage.

_____ _____

Date **Signature of Parent/Guardian**