ATHLETIC PRE-PARTICIPATION FORMS

Dear Parent/Guardian:

In order to insure efficient and appropriate health care for your child, we must ask you to complete several forms before allowing your child to participate in interscholastic athletics or extracurricular activities. ***It is EXTREMELY IMPORTANT that NO* parts of the form be left blank. Incomplete forms will NOT be accepted!**

Per South Carolina High School League rules, pre-participation physicals are valid from April 1, 2018 – May 31, 2019.

If you should have any questions or concerns about this process, please do not hesitate to contact the Athletic Trainer at your child's high school.

ALL FORMS MUST BE COMPLETED AND RETURNED TO THE ATHLETIC TRAINING ROOM AT YOUR CHILD'S SCHOOL BEFORE YOUR CHILD WILL BE ALLOWED TO PARTICIPATE IN ANY TRY-OUT, PRACTICE, OR GAME.

Please follow the directions below for completing the attached physical forms . . .

1) Parent/Guardian ***AND*** student athlete ***READ, SIGN, and DATE*** "HIPPA Form"
2) Parent/Guardian ***AND*** student athlete ***COMPLETE*** "Student information sheet."
3) Parent ***COMPLETE, SIGN, AND DATE*** the "Authorization for Release of Medical Information Form."
4) Parent/Guardian ***AND*** student athlete ***READ, SIGN, and DATE*** "Parent/Guardian Consent Form"
5) Parent ***AND*** student athlete ***READ, SIGN, AND DATE*** the "Mild Traumatic Brain Injury (MTBI) / Concussion Annual Statement and Acknowledgement Form for Student Athletes"
6) ***COMPLETELY fill out*** the "Pre-participation Health Screening" form, then sign and date it at the bottom. *It is* ***EXTREMELY IMPORTANT*** *that* ***NO*** parts of the form be left blank Incomplete forms will **NOT** be accepted!
7) Take the forms to your doctor and have them complete the physical examination portion of the physical form.

NOTE: Physical forms MUST be signed by a licensed medical doctor in South Carolina or a Certified Physician's Assistant or Family Nurse Practitioner practicing under the supervision of a licensed South Carolina MD or DO. Chiropractor signatures are NOT valid!

Per South Carolina High School League rules, pre-participation physicals are valid from April 1, 2018 – May 31, 2019.

Tidelands Health
Sports Medicine Institute

Disclosure Authorization Privacy Practices
HIPAA Form

I,_____(student's name) and my parents/legal guardians/adult responsible for my care,_____(parents/legal guardian/adult responsible-circle one applicable) hereby authorize Tidelands Health and its athletic trainers to disclose to the Georgetown County School System, coaches, athletic staff and any other person involved in the operation, administration or management of the Georgetown County Board of Education sanctioned extracurricular sports programs at area district schools, as well as student's parents/legal guardians/adult responsible, any medical or health information relevant to student's involvement or participation in such extracurricular sports programs. Such disclosure shall be for the purpose of communicating student's ability to participate or continue participation in an extracurricular sports program, including whether student has suffered any injury, the extent of such injury, the impact such injury could make on continued participation, whether student's condition requires further treatment, and whether there should be any adjustment to student's participation in such extracurricular sports programs in the Georgetown County School System. This authorization shall terminate when the season for the extracurricular sports program in which student is participating ends, including any post-season (e.g. tournament) play. This authorization also continues through each sport (multiple sports) that the student may play. The undersigned have the right to revoke this authorization at any time by providing the Tidelands Health Compliance Officer notice in writing. Exceptions to this right of revocation and a description of how this authorization may be revoked are contained in the Tidelands Health Notice of Privacy Practices. Tidelands Health's athletic trainers will not condition treatment on whether this authorization is signed; however , the Georgetown County School System will not permit any student to participate in any extracurricular sports games or tournament play attended by an athletic trainer if the student and his/her parents/legal guardians/adult responsible have not signed an authorization. The undersigned understands and agrees that medical or health information disclosed by Tidelands Health or its athletic trainers pursuant to this authorization may be subsequently disclosed by the recipient and may no longer be protected by applicable law.

In addition to the foregoing, the undersigned hereby acknowledges receipt of Tidelands Health Notice of Privacy Practices.

_____ _____

Student's Signature Date

_____ _____

Parent/Legal Guardian/Responsible Adult Date

STUDENT-ATHLETE INFORMATION

Name _____ **Sex** {circle} M F **Grade** {circle} 7 8 9 10 11 12
FIRST MIDDLE LAST (2018-2019 School Year)

Date of Birth _____/_____/_____
Month Day Year

Mailing Address _____ **City** _____ **Zip Code** _____

Home Phone _____ **Cell Phone** _____ **Email** _____

Parent/Guardian Information:

Father _____ _____ **Home Phone** _____ **Cell Phone** _____

Email _____

Employer _____ **Work Phone** _____

Mother _____ **Home Phone** _____ **Cell Phone** _____

Email _____

Employer _____ **Work Phone** _____

Emergency Contact _____ **Phone** _____ **Alternate** _____

Family Doctor _____ ___ **Phone** _____ **Alternate** _____

Is this student covered by private health care/medical insurance and/or Medicaid? _____ **Yes** _____ **No**

Medicaid Provider: _____ **Medicaid#:** _____

Name of private healthcare/medical insurance provider: _____

Policy Holder's Name: _____ **Social Security #** : _____ - _____ - _____

Group Name: _____ **Group #:** _____ **Policy #:** _____

Please indicate which school your child attends (Base school by attendance area):

_____ Carvers Bay HS _____ Carvers Bay MS _____ Andrews HS _____Rosemary MS

_____ Georgetown HS _____ Georgetown MS _____ Waccamaw HS _____ Waccamaw IMS

_____ Waccamaw MS

THIS FORM MUST BE COMPLETED, SIGNED, AND RETURNED TO SCHOOL WITH PHYSICAL!

Authorization for Release of Medical Information

Student's Name: _____ **Date of Birth:** ____ / ____ / _____
First Middle Initial Last Month Day Year

Grade: _____
(2018-2019)

I hereby authorize Georgetown County Schools to obtain, use, and disclose my child's protected health information ("Health Information") as defined by Federal and state law, in the manner described below. I understand that this authorization is voluntary. I also understand that if the person or entity authorized by this document to provide or receive my child's Health Information is not a health plan or health-care provider, then the disclosed Health Information may no longer be protected from further disclosure by federal or state law.

Any and all of the following Health Information may be obtained, used, or disclosed by Georgetown County Schools**:**

Please check the appropriate box…

☐ **All records**, including those listed below
☐ Pre-participation Physical Forms only
☐ Medical Records only
☐ Insurance Claims/Medical Billing and/or Medicaid Information only

This information may be obtained from, used by/for, or disclosed to, the following individual(s) and/or entities:

Please check the appropriate box…

☐ **All** of the individuals/entities listed below
☐ Affiliated Team Physicians only
☐ Affiliated Allied Health Care Providers such as Physical Therapists, Counselors, etc. only
☐ Family Physician only (Physician's Name(s): _____)
☐ School Athletic Insurance Policy Provider only
☐ Primary Insurance Policy Provider only
☐ Another school(s) in the event of a student transfer only.
☐ Other, please list the contact information here: Name:_____

Mailing Address: _____

_____

Telephone Number: _____

I understand that my child's healthcare will not be affected if I do not sign this form.

This authorization shall expire one year from the date of my signature below.

I understand that I may revoke this authorization at any time by notifying Georgetown County Schools in writing. I understand that my revocation of this authorization will not affect any actions taken by Georgetown County Schools in reliance on this authorization prior to the time it received my revocation.

I understand that I have a right to receive a copy of this authorization.

Signature: _____ Date: _____

Relationship to student listed above (please check one) ☐ Parent ☐ Legal guardian
***A photocopy or facsimile of this document shall be considered the same as the original document.*

THIS FORM MUST BE COMPLETED, SIGNED, AND RETURNED TO SCHOOL WITH PHYSICAL!

PARENT/GUARDIAN CONSENT, WAIVER, AND MEDICAL RELEASE FORM FOR ATHLETICS 2018-2019

STUDENT'S FULL NAME:_____**DATE OF BIRTH:** _____

SCHOOL:_____ **HOME PHONE #:** _____

PARENT/GUARDIAN:_____**OTHER PHONE #:** _____

I hereby give permission for the above-named student to participate in the interscholastic athletic program beginning the date I have signed this form through May 31, 2019, and to travel on athletic trips scheduled for his/her team(s). In granting this permission, I assume full responsibility for the behavior of my child and for any and all damages to person or property caused by my child.

As a parent or legal guardian of the above named student athlete, I give permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular healthcare. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of the athletic injury prevention and treatment, to have access to necessary medical information. I know the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

I understand that participation in athletics is a privilege and an opportunity for my child. In that regard, I agree that if it is determined that my child needs medical or dental treatment as the result of athletic participation and incurs resulting costs and those costs are not otherwise covered, it ultimately is my financial responsibility to cover the cost of any treatment provided by a physician, dentist, athletic trainer, emergency medical personnel or any other medical personnel.

I give my permission for the school district's sports medicine staff to care for and provide appropriate medical treatment for my child in the event of his/her injury.

I agree to notify the athletic trainer immediately in writing of any changes in my child's health which requires modification to my permission. My child and I understand that all school related athletic injuries are to be reported to the Certified Athletic Trainer at their school as soon as possible.

I understand that by participating in interscholastic athletics, including practices, my child is exposing himself/herself to the risk of serious injury and death. By my signature below I release and waive, and further agree to indemnify, hold harmless or reimburse the Georgetown County School District, the individual members, employees, representatives, and agents thereof, from and against, any claim which I, any other parent or guardian, any sibling, my child, or any other person, firm, or corporation may have or claim to have, known or unknown, directly or indirectly, for any losses, damages, injuries, or adverse reactions arising out of, during, or in connection with my child's participation in athletic competition(s) and/or practice(s) and in connection with the administration of medication(s) to my child as specified above. I agree that a photocopy or facsimile of this document shall be considered the same as the original document.

I HAVE READ AND UNDERSTAND THIS RELEASE AGREEMENT AND THE "INFORMATION CONCERNING PARTICIPATION IN SPORTS" PRESENTED WITHIN THIS RELEASE AGREEMENT. MY CHILD AND I HAVE DISCUSSED THE RISKS INHERENT IN PLAYING_____ (indicate sports) AND WE HAVE AGREED THAT WE WISH TO ASSUME THAT RISK.

_____ _____
Signature of Student Athlete Date

_____ _____
Signature of Parent/Guardian Date

Note: This form becomes obsolete at the end of the day May 31, 2019, but must be maintained by the school for a period consistent with the school district's records retention schedule.

Revised: 10/2015

THIS FORM MUST BE COMPLETED, SIGNED, AND RETURNED TO SCHOOL WITH PHYSICAL!

Mild Traumatic Brain Injury (MTBI) / Concussion
Annual Statement and Acknowledgement Form for Student-Athletes
2018-2019

I, _____ (student), acknowledge that I have to be an active participant in my own health and have the direct responsibility for reporting all of my injuries and illnesses to the appropriate school staff (e.g., coaches, athletic training staff, and school nurse). I further recognize that my physical condition is dependent upon providing an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced before, during or after athletic activities.

By signing below, I/We acknowledge:

- My school has provided me with specific educational materials including the CDC Concussion fact sheet (http://www.cdc.gov/concussion/HeadsUp/youth.html) on what a concussion is and has given me an opportunity to ask questions.
- I/We have fully disclosed to the school medical staff any prior mild traumatic brain injuries (MBTI)/concussions and will also disclose any future conditions.
- There is a possibility that participation in my sport may result in a head injury and/or concussion. In rare cases, these concussions can cause permanent brain damage, and even death.
- A concussion is a brain injury, which I/We am/are responsible for reporting to the coach, athletic trainer, school nurse, or other appropriate school medical staff member.
- A concussion can affect my ability to perform everyday activities, and affect my reaction time, balance, sleep, and classroom performance.
- Some of the symptoms of concussion may be noticed right away while other symptoms can show up hours or days after the injury.
- If I suspect a teammate has a concussion, I will make every effort to report the injury to the appropriate school staff and/or school medical staff member.
- I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion related symptoms.
- I will not return to play in a game or practice until my symptoms have resolved AND I have written clearance to do so by a qualified health care professional.

I represent and certify that I and my parent/guardian have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Student Athlete must print their name, then sign and date below:

Print Name: _____ Signature: _____

Date: _____

Parent/Guardian must print their name, then sign and date below:

Print Name: _____ Signature: _____

Date: _____

Georgetown County School District

PRE-PARTICIPATION HEALTH SCREENING FOR ATHLETICS / EXTRACURRICULAR ACTIVITIES

Name _____ **Sex: M F Grade: 7 8 9 10 11 12 Date of Birth** ____/_____/_____
FIRST MIDDLE LAST **(2018-2019 School Year)** Month / Day / Year

Sports you plan to play {√ all that apply} ____ **Football** ____ **Basketball** ____ **Baseball** ____**Softball**
____ **Volleyball** ____ **Wrestling** ____ **Cross Country** ____ **Soccer** ____ **Track** ____**Swimming**
____ **Golf** ____ **Lacrosse** ____ **Cheerleading** ____ **Tennis** ____ **NJROTC** ____ **Dance Team**

Medical History **(Answer ALL questions by checking the YES or NO boxes. Explain ALL "Yes" answers in the space below!**

	GENERAL MEDICAL HISTORY:	**YES**	**NO**	**Don't Know**
1.	**HAVE YOU HAD ANY MEDICAL PROBLEM OR PHYSICAL INJURY SINCE YOUR LAST PHYSICAL EXAM?**	☐	☐	☐
2.	DO YOU HAVE ASTHMA?	☐	☐	☐
3.	DO YOU HAVE DIABETES?	☐	☐	☐
4.	DO YOU HAVE HIGH BLOOD PRESSURE?	☐	☐	☐
5.	DO YOU HAVE SEIZURES?	☐	☐	☐
6.	DO YOU HAVE SICKLE CELL TRAIT?	☐	☐	☐
7.	HAVE YOU HAVE ANY OTHER MAJOR MEDICAL PROBLEM?	☐	☐	☐
8.	HAVE YOU EVER BEEN HOSPITALIZED OR HAD SURGERY?	☐	☐	☐
9.	DO YOU COUGH, WHEEZE, OR HAVE TROUBLE BREATHING WHEN EXERCISING?	☐	☐	☐
10.	DO YOU USE AN INHALER?	☐	☐	☐
11.	DO YOU HAVE A SINGLE ORGAN (TESTICLE OR KIDNEY)?	☐	☐	☐
12.	ARE YOU CURRENTLY TAKING ANY MEDICINES OR DO YOU TAKE ANY MEDICINES ON A REGULAR BASIS (PRESCRIPTION OR OVER-THE-COUNTER)?	☐	☐	☐
13.	HAVE YOU EVER TAKEN ANY SUPPLEMENTS OR VITAMINS TO HELP WITH WEIGHT LOSS, WEIGHT GAIN, OR TO IMPROVE PERFORMANCE?	☐	☐	☐
14.	DO YOU HAVE ANY ALLERGIES (SEASONAL, INSECTS, FOOD, OR MEDICINES)?	☐	☐	☐
15.	HAVE YOU EVER HAD A RASH OR HIVES DEVELOP DURING OR AFTER EXERCISE?	☐	☐	☐
16.	DO YOU HAVE ANY SKIN PROBLEMS OTHER THAN ACNE?	☐	☐	☐
17.	HAVE YOU EVER HAD A HEAD INJURY, BEEN KNOCKED OUT, LOST YOUR MEMORY, HAD YOUR "BELL RUNG", OR A CONCUSSION?	☐	☐	☐
18.	HAVE YOU EVER HAD NUMBNESS OR TINGLING IN YOUR ARMS, HANDS, LEGS, OR FEET?	☐	☐	☐
19.	HAVE YOU EVER HAD A "STINGER", "BURNER", OR PINCHED NERVE?	☐	☐	☐
20.	HAVE YOU EVER BECOME ILL FROM EXERCISING IN THE HEAT?	☐	☐	☐
21.	HAVE YOU HAD MONONUCLEOSIS OR ANY SIGNIFICANT ILLNESS IN THE LAST 60 DAYS?	☐	☐	☐
22.	DO YOU HAVE TROUBLE WITH YOUR EYES/VISION/WEAR GLASSES OR CONTACTS?	☐	☐	☐
23.	DO YOU HAVE TROUBLE WITH YOUR HEARING/WEAR HEARING AIDS?	☐	☐	☐
24.	DO YOU WANT TO WEIGH MORE OR LESS THAN YOU DO NOW?	☐	☐	☐
25.	DO YOU LOSE WEIGHT REGULARLY TO MEET WEIGHT REQUIREMENTS FOR YOUR SPORT OR OTHER REASONS	☐	☐	☐
26.	DO YOU FEEL STRESSED OUT, OVERLY TIRED, OR DEPRESSED?	☐	☐	☐
27.	ARE THERE ANY OTHER ISSUES YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR?	☐	☐	☐
	CARDIAC HISTORY:			
1.	HAVE YOU EVER PASSED OUT DURING OR AFTER EXERCISE	☐	☐	☐
2.	HAVE YOU EVER BEEN DIZZY DURING OR AFTER EXERCISE?	☐	☐	☐
3.	HAVE YOU EVER HAD CHEST PAIN OR CHEST PRESSURE DURING OR AFTER EXERCISE?	☐	☐	☐
4.	DO YOU TIRE EASILY OR MORE QUICKLY THAN YOUR FRIENDS DURING EXERCISE?	☐	☐	☐
5.	HAVE YOU EVER HAD RACING OF YOUR HEART OR SKIPPED HEARTBEATS?	☐	☐	☐
6.	HAVE YOU EVER BEEN TOLD YOU HAD A HEART MURMUR?	☐	☐	☐
7.	HAVE YOU EVER BEEN TOLD YOU HAD AN ENLARGED HEART?	☐	☐	☐
8.	HAS ANY MEMBER OF YOUR FAMILY:	☐	☐	☐
	☐ - DIED OF HEART PROBLEMS OR SUDDEN DEATH BEFORE AGE 50? ☐ - BEEN TOLD THEY HAD A SERIOUS HEART PROBLEM BEFORE AGE 50 ☐ - BEEN TOLD THEY HAD MARFAN'S SYNDROME			
9.	HAS A PHYSICIAN EVER DENIED OR RESTRICTED YOUR PARTICIPATION IN SPORTS?	☐	☐	☐
	ORTHOPAEDIC HISTORY:			
1.	HAVE YOU EVER BROKEN OR FRACTURED ANY BONES?	☐	☐	☐
2.	HAVE YOU EVER DISLOCATED OR PARTIALLY DISLOCATED ANY JOINT?	☐	☐	☐
3.	HAVE YOU HAD ANY PROBLEMS RELATED TO YOUR:	☐	☐	☐
	☐ - NECK, SPINE, OR BACK ☐ – SHOULDERS ☐ – ELBOWS ☐ -WRISTS, HANDS, OR FINGERS ☐ – HIPS ☐ – KNEES ☐ - ANKLES, FEET, OR TOES ☐ - OTHER			
	FEMALES ONLY:			
1.	ARE YOUR PERIODS REGULAR (EVERY MONTH)?	☐	☐	☐
2.	ARE YOUR PERIODS HEAVY?	☐	☐	☐
3.	WHEN WAS YOUR FIRST PERIOD? MONTH _____ YEAR _____			
4.	WHEN WAS YOUR LAST PERIOD? MONTH _____ YEAR _____			

Please explain YES answers from above in this space:

_____

_____

_____

Signature of parent/guardian: _____ **Date signed:** _____

***A photocopy or facsimile of this document shall be considered the same as the original document.*

Please note…Per South Carolina High School League rules, pre-participation physicals are valid from April 1, 2018– May 31, 2019.

Pre-participation Health Screening Examination

Date of Examination: _____

Physical Examination

Name: _____ **Age:** _____ **Date of Birth:** _____/_____/_____

LIMITED

HEIGHT _____ WEIGHT _____

PULSE _____ BP _____/_____ RESPIRATION _____

VISION R 20/_____ L 20/ _____ CORRECTED (CIRCLE): YES / NO
IF YES, WITH? (CIRCLE) GLASSES / CONTACTS

COMPLETE

	NORMAL	ABNORMAL FINDINGS	INITIALS
CARDIOPULMONARY			
PULSES (INCLUDING FEMORAL)			
HEART (SUPINE & SQUAT TO STANDING)			
LUNGS			
SKIN			
ABDOMINAL			
GENITALIA			
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS**
NECK			
SHOULDERS			
ELBOWS			
WRISTS			
HANDS			
BACK/SPINE			
HIP/PELVIS			
KNEES			
ANKLES			
FEET			
DENTAL EXAM	**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS**
GUMS AND TONGUE			
TEETH			
TMJ JOINT			

Clearance (check one): ☐ CLEARED ☐ Cleared ***after*** completing evaluation/treatment for: _____

☐ **NOT CLEARED** for sport/activity (list) _____

☐ **NOT CLEARED FOR ANY SPORTS PARTICIPATION** due to: _____

Other recommendations: _____

Name of Examining Physician: _____ Phone Number: _____

Physician Office Name: _____

Signature of Examining Physician: _____ Date: _____

Please note…Per South Carolina High School League rules, pre-participation physicals are valid from April 1, 2018 – June 30, 2019.