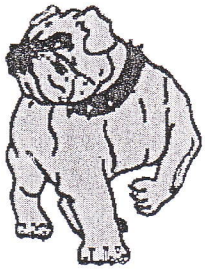
Student name: _____



In order for the student athlete to participate in Georgetown Middle School (GMS) **OR** Georgetown High School (GHS) Athletics, they must complete the enclosed information. Please make sure all of the information is correctly filled out and signed.

No child can participate in an athletic event before all of this information is turned in to the Athletic Director.

- ☐ HIPAA Form
- ☐ Student Information Sheet
- ☐ Pre-participation Physical Evaluation (History Form)
- ☐ Pre-participation Physical Evaluation (Physical Examination Form)
- ☐ Parent Acknowledgement Statement
- ☐ MBTI/ Concussion Statement
- ☐ Birth Certificate *(school records)*
- ☐ Current Grades *(school records)*

Tidelands Health Nexstep Sports Medicine

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 Georgetown High School, 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

_____ _____

Parent/Legal Guardian/Responsible Adult Date

GEORGETOWN COUNTY DISTRICT STUDENT INFORMATION SHEET
GEORGETOWN HIGH SCHOOL

PLEASE CLEARLY FILL OUT (IN BLUE OR BLACK INK) AND RETURN TO THE ATHLETIC TRAINER

Athlete's Full Name_____ Sports_____

Athlete's Home Address_____
Street City State Zip

Athlete's Home Phone/Cell_____ Date of Birth_____

Athlete's Grade/Class Level as of Next Fall_____ Athlete's Social Security Number_____

Athlete's Gender (Please Circle One) Male Female Race_____

Parent/Guardian Information (For Emergency and Insurance Purposes)

Father's Name_____

Father's Home Address_____
Street City State Zip

Father's Date of Birth_____ Father's Social Security Number_____

Father's Place of Employment_____

Father's Home Phone/Cell_____ Work Phone_____

Mother's Name_____

Mother's Home Address_____
Street City State Zip

Mother's Date of Birth_____ Mother's Social Security Number_____

Mother's Place of Employment_____

Mother's Home Phone/Cell_____ Work Phone_____

Insurance Information (Fill Out Completely)

The Athlete has Medical Coverage (Circle One) Yes No

The Athlete is covered by Medicaid (Circle One) Yes No If yes Medicaid Number_____

Name of Policy Holder_____

Relationship to Athlete_____ Date of Birth of Insured_____

Social Security Number of Insured_____ Policy Number_____

Insurance Compnay_____

Address of Company_____
Street City State Zip

Phone Number of Company_____ Is this Policy an HMO?_____ PPO?_____

Assumption of Risk

I, the above mentioned athlete, understand that by choosing to participate in athletics there is an inherent risk of sustaining an athletic injury. These injuries may range from minor to catastrophic. I understand that proper conditioning and the use of proper techniques may prevent many of these injuries and/or conditions.

Athlete's Signature_____ Date_____

Parent's/Guardian's Signature_____ Date_____

Consent to Treat

In the event that my child sustains an injury/illness, I give permission for the athletic trainers, physical therapists, physicians and coaches permission to evaluate and treat my child as they deem fit.

Athlete's Signature_____ Date_____

Parent's/Guardian's Signature_____ Date_____

Release of Medical Records

I authorize the release of any medical records and/or information to the athletic trainers, physicians, insurance companies, Georgetown Hospital System and to Georgetown High School.

Athlete's Signature_____ Date_____

Parent's/Guardian's Signature_____ 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 a copy of this form in the chart.)

Name _____ Sex __F __M Age ___ Date of Birth _____ Grade ___

School _____ Sport(s) _____ Date of Exam _____

Address _____ Phone _____

EMERGENCY CONTACT NAME _____ Relationship _____ Phone _____

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

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. Doe 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	**Yes**	**No**
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 accurate.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

As the parent or legal guardian of the above named student-athlete, I give my 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 health care. 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, athletic trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that 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.

Signature of athlete _____ Date _____

Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

EXAMINATION			
Height	Weight	☐ Male ☐ Female	
BP / (/)	Pulse	Vision R 20/ L20/	Corrected ☐ Yes ☐ No
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]			
MUSCOSKELETAL			
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 participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolve 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

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

Name (please print) _____

As a parent or legal guardian of the above names 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 health care. 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 athletic injury prevention and treatment, to have access to necessary medical information. I know that 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.

Signature of Athlete _____ _____
Date

Signature of Parent/Guardian _____ _____
Date

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

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:

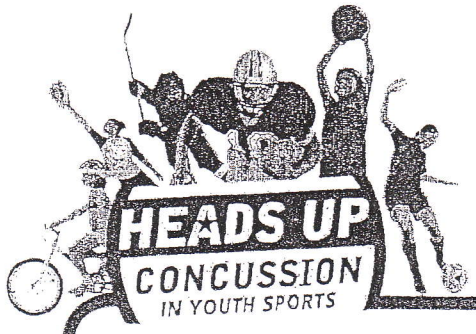
Print Name: _____ Signature: _____

Date: _____

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

Print Name: _____ Signature: _____

Date: _____



A Fact Sheet for **ATHLETES**

CONCUSSION FACTS

A concussion is a brain injury that affects how your brain works.

- A concussion is caused by a bump, blow, or jolt to the head or body.
- A concussion can happen even if you haven't been knocked out.
- If you think you have a concussion, you should not return to play on the day of the injury and not until a health care professional says you are OK to return to play.

CONCUSSION SIGNS AND SYMPTOMS

Concussion symptoms differ with each person and with each injury, and they may not be noticeable for hours or days. Common symptoms include:

- Headache
- Confusion
- Difficulty remembering or paying attention
- Balance problems or dizziness
- Feeling sluggish, hazy, foggy, or groggy
- Feeling irritable, more emotional, or "down"
- Nausea or vomiting
- Bothered by light or noise
- Double or blurry vision
- Slowed reaction time
- Sleep problems
- Loss of consciousness

During recovery, exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse.

WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

- **DON'T HIDE IT. REPORT IT.** Ignoring your symptoms and trying to "tough it out" often makes symptoms worse. Tell your coach, parent, and athletic trainer if you think you or one of your teammates may have a concussion. Don't let anyone pressure you into continuing to practice or play with a concussion.
- **GET CHECKED OUT.** Only a health care professional can tell if you have a concussion and when it's OK to return to play. Sports have injury timeouts and player substitutions so that you can get checked out and the team can perform at its best. The sooner you get checked out, the sooner you may be able to safely return to play.
- **TAKE CARE OF YOUR BRAIN.** A concussion can affect your ability to do schoolwork and other activities. Most athletes with a concussion get better and return to sports, but it is important to rest and give your brain time to heal. A repeat concussion that occurs while your brain is still healing can cause long-term problems that may change your life forever.

HOW CAN I HELP PREVENT A CONCUSSION?

Every sport is different, but there are steps you can take to protect yourself.

- Follow your coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

It's better to miss one game than the whole season.

For more information, visit www.cdc.gov/Concussion.