Chattooga County Athlete Physical Insurance and Consent Form

***Parents Signature needed in THREE places**

PLEASE PRINT GRADE _____ _____
(Nickname if any)

Name _____ _____ _____
(Last) (First) (Middle)

CONTACT INFO

HOME: _____ CELL:_____ CELL:_____

WHO: _____ WHO: _____

****

PARENTAL CONSENT FOR ATHLETIC PARTICIPATION

WARNING: Although participation in supervised inter-scholastic athletics and activities may be one of the least hazardous in which students will engage in or out of school, **BY ITS NATURE, PARTICIPATION IN INTER-SCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG TERM CATASTROPHIC, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH.** Although serious injuries are not common in supervised school athletic programs, it is possible only to minimize, not eliminate the risk.

Participants can and have the responsibility to help reduce the chance of injury. **PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR EQUIPMENT DAILY.**

By signing this permission form, you acknowledge that you have read and understand this warning. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM.**

I (We) hereby give consent for my child,_____ to:

(1) Compete in athletics for the Chattooga County School District in Georgia

Sports Offered:

Cheerleading Basketball Softball Track & Field

Volleyball Weight Training Football Wrestling Tennis _____

(2) Accompany any school team of which he/she is a member on any of its local or out-of-town trips.

(3) I hereby verify that the information on both sides/pages of this form is correct and understand that any false information may result in my son/daughter being declared ineligible;

(4) and, I consent to Internet storage and delivery of this information to medical providers as appropriate by DCATS.com,LLC

This acknowledgement of risk and consent to allow participation shall remain in effect until revoked in writing.

SIGNATURE(S) OF PARENT(S) OR GUARDIAN(S) _____
(Use Ink) Date: _____

INSURANCE INFORMATION

Please INITIAL one of the following statements regarding insurance coverage for your son/daughter for the school year, then sign below.

_____ My son/daughter is adequately and currently covered by accident insurance that will cover injuries sustained while participating in any school authorized activities (including but not limited to, Football).

Company Providing Insurance Name of Insured Policy Number

_____ _____ _____

_____ *I have purchased School Insurance. Policy Number* _____

*SIGNATURE(S) OF PARENT(S) OR GUARDIAN(S) _____

(USE INK) Date: _____

AUTHORIZATION

I certify that the medical history on this form is complete and accurate. I understand that this will serve as the basis for determining that my child may compete in Chattooga County schools athletics program. I also understand that this medical evaluation is only to determine fitness for athletics and is not to take the place of regular medical examinations. In case of an emergency or accident on the school grounds or during any school activity involving my child, which in the opinion of school authorities present requires immediate medical or surgical attention, I hereby grant permission to said school authorities to obtain the services of the physician or to transport my child, to the hospital if it is deemed necessary by school authorities. I hereby grant permission, also, to said physicians to treat said condition unless I am present and request otherwise or until I request otherwise.

This acknowledgement of authorization shall remain in effect until revoked in writing.

(Use Ink)*SIGNATURE _____ Date _____

Relation to Student: (Circle) Mother Father Other

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: D Asthma D Anemia D Diabetes D 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 ail that apply: D High blood pressure D A heart murmur D High cholesterol D A heart infection D 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 aT syndrome, short aT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibriilator?		
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, swoilen, 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 failing?		
39. Have you ever been unable to move your arms or legs after being hit or failing?		
40. Have you ever become iil while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle ceil 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. Howald 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 _____

PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICAL 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 3D 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 pertormance supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your pertormance?
- 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 • Martan 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'		
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.
'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 contra indications 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

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 _____

_____

_____

_____

_____