Richmond County School System Interscholastic CONTRACT for Parents and Student-Athletes

1. I understand that each student participating student in athletics, extracurricular, co-curricular, and interscholastic activities is expected to maintain at least a **75 average** (this is the average of all of the student athlete's classes at any given time) in order to remain eligible. I also understand that progress reports will be done every three (3) weeks and I must sign the report and return to the school. I also understand that if my child does not maintain academic achievement, that he/she will be removed from participation until such grades have improved and academic expectations and requirements have been met.

2. I understand that my child is expected to attend all practices, rehearsals, meetings, and events to arrive promptly and to remain throughout the scheduled hours. I also agree to provide a written excuse for missed practices and pick up my child after practices, rehearsals, meetings, and events have ended.

3. I understand that my child is to cooperate and conduct him or herself with administrators, teachers, coaches, spectators, officials, and team members in a manner showing respect to all persons.

4. I understand that my child must adhere to all school policies and policies of the Richmond County Board of Education.

5. I understand that my child must maintain the highest standards of honesty and integrity while representing the school and the school system of Richmond County.

6. I understand that my child is to respect and care for all equipment and supplies issued by the Richmond County School System. I also understand that I am held financially responsible for any theft, damage, or loss of any of the equipment or supplies issued to my child by the Richmond County School System.

The privilege of representing a school rests upon the personal responsibility of the child and the parent. In consideration of the County Board of Education of Richmond County offering athletics, extracurricular, co-curricular, and interscholastic activities and selecting my child as a member, I promise that my child will attend school regularly, maintain high academic standards, and be cooperative and respectful of others. This contract is for the **2020-2021** school year.

This contract becomes effective this_____day of_____, 20_____

Signature of Parent/Guardian: _____

Signature of Student/Athlete: _____

ATHLETE ROSTER

Date:____/____/____ Sport(s):_____

Name: _____ Birthdate:____/____/_____

Sex: [M] [F] Grade: _____

Address: _____

_____

Name of Parent(s)/Guardian(s): _____

Address If Different From Above: _____

_____

Home Phone#: (Mother) _____ (Father): _____

Cell Phone #: (Mother) _____ (Father): _____

Business Phone #: (Mother)_____(Father): _____

PERSON OTHER THAN PARENT/GUARDIAN TO CONTACT IN CASE OF EMERGENCY:

Name:_____ Relation: _____

Address: _____

_____

Home #:_____Cell#_____Business#_____

FAMILY PHYSICIAN INFORMATION:

Physician Name:_____ Specialty: _____

Address/Location: _____

_____

Office Phone#: _____ After Hours/Emergency#: _____

INSURANCE COMPANY INFORMATION:

1. THIS INFORMATION IS REQUIRED FOR YOUR STUDENT ATHLETE TO BE ABLE TO PARTICIPATE IN ALL SPORTS. FAILURE TO PROVIDE THIS INFORMATION WILL PROHIBIT PARTICIPATION IN SPORTS).
2. IF YOU ARE MILITARY, PLEASE PROVIDE YOUR SOCIAL SECURITY NUMBER. IF YOU DO NOT WANT TO USE YOU'RE YOUR SOCIAL SECURITY NUMBER YOU WILL NEED TO COMPLETE A MILITARY INSURANCE POLICY FORM. PLEASE SEE A COACH FOR MORE INFORMATION. THANKS!

Primary: _____ Policy#: _____

Secondary: _____ Policy#: _____

Specific Medication, Allergies, Medical Problems of the Athlete: _____

_____

_____

Please Completely Fill Out All Of The Information On This Page. Failure To Completely Filling Out The Athletic Roster Form Will Prohibit The Student/Athlete From Participating In Any Sports Activity. Thanks!

PARENT PERMISSION FOR STUDENT ATHLETIC PARTICIPATION

Dear Parent(s) or Guardian(s):

The school's athletic program is an integral part of the curriculum, and school personnel have devoted great effort to assure that participating students are protected in every way possible. However, participation in athletics includes a risk of injury which may range in severity from minor to long-term catastrophic, including paralysis and death.

Participants have the responsibility to help reduce the chance of injury. Participants must obey all safety rules and regulations, participate in all required physicals, report all physical problems to the coach or athletic trainer, follow a proper conditioning program and inspect personal protective equipment daily. Proper execution of skill techniques must be followed for every sport.

It is the policy of the Richmond County Board of Education that all athletic participants, other than football, provide either proof of insurance, purchase the student accident insurance policy that is sanctioned by the board, or sign a military waiver, provided by the school for military dependents.
Participants in football must either provide proof of insurance, sign a military waiver, or purchase the football policy carried by the student accident insurance company. The school's athletic program is not authorized to extend public funds for injuries; thus, it will be the responsibility of the parent or guardian to pay any costs for any injury, which is not covered by insurance.

(PLEASE INITIAL EACH OF THE FOLLOWING STATEMENTS TO SHOW THAT THE STATEMENT HAS BEEN READ, UNDERSTOOD, AND APPROVED.)

_____ I consent to have my son/daughter represent his/her school in approved athletic activities except those activities excluded by the examining doctor.

_____ I grant permission for my son/daughter to accompany any school team of which he/she is a member to out-of-town trips. The athlete will be transported to and from all events in school approved vehicles. Parents/Guardians wishing to have their son/daughter with them returning from an event must make written arrangements with the coach.

_____ In the event of an emergency requiring medical attention, I understand every attempt will be made to contact me. In case I cannot be reached, I grant permission for any immediate treatment deemed necessary by the attending physician and transfer of my son/daughter to a qualified medical facility. This authorization does not cover major surgery unless formally decreed prior to surgery by two licensed physicians or dentists.

_____ I agree not to hold the school or anyone acting on its behalf responsible for any injury occurring to my son/daughter in the proper course of such athletic activities or travel.

_____ I acknowledge and accept that there are risks of physical injury involved in athletic participation which may result in permanent paralysis, mental disability, and death.

Date: ____/____/____Parent Guardian Signature: _____

Date:____/____/____Parent Guardian Signature: _____

Parents/Guardians, Please Read, Initial, Sign and Date. This Form Needs Your Initials and Signatures To Complete The Physical Process. Thanks!

PRE-PARTICIPATION 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.)

Name:_____ **Date of Exam**____/____/____

Date of Birth:____/____/____ **Sex:** ____ **Age:** ____ **School:** _____

Sports: _____

Medicines and Allergies: Please list all of the prescriptions 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: ☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "yes" answers below. Circle answers in which you do not know the answer.

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 identify: ☐ 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, lightness, or pressure in your chest during exercise?		
7. Does your heart 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 ever 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 ABOOUT YOUR FAMILY		
13. Has any family member or relative died of heart problems or had an unexpected death or unexplained sudden death before age 50 (including drowning, unexpected 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 defibulator?		
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 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, orcrutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have 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. Where you born without or are you missing a kidney, an eye, a testicle (male), 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 MSRA infection?		
34. Have you 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 disorders?		
37. Do you have headaches with exercise?		
38. Have you 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 problem 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 food?		
50. Have you ever had an eating disorder?		
51. Do you have an concerns that you would like to discuss with the doctor?		
FEMALE 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 month?		

Explain "YES" answers here: _____

_____

_____

_____

_____

_____

_____

_____

_____

IMPORTANT! All Questions Must Be Answered; All Signatures Should Be Signed And Dated. Physicals Will Not Be Given If These Directions Are Not Followed. Thanks!

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:**____/____/____

PRE-PARTICIPATION PHYSICAL EVALUATION

Physical Examination Form

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

Students, Please Put Your Name And Birthday On This Form Before Giving It To The Physician. All Other Information Will Be Filled Out By The Physician. Incomplete Paper Work Will Not Be Accepted.

Physician Reminders

1. Consider additional questions on more sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at home or residence?
   - Have you ever tried cigarettes or chewing tobacco, snuff, or dip?
   - During the past 30 day, 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 helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5-14 on other side of form).

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[1] ***** Murmurs (auscultation standing, supine, +/-, Valsalva) * Location of point of maximal impulse (PMI)		
Pulses ***** Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[2]		
Skin *****HSV, lesions suggestive of MSRA, tinea corporis		
Neurologic[3]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Legs/Ankle		
Foot/Toes		
Functional *Duck-walk, single leg hop		

[1] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[2] Consider GU exam if in private setting, Having third party present is recommended.
[3.] Consider cognitive evaluation or baseline neuropsychological 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 pre-participation physical evaluation. The athlete does not present apparent clinical contradictions 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/guardian).

Name of physician (print/type):_____ Date: _____

Address:_____ Phone: _____

Signature of physician:_____MD or DO

PRE-PARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name:_____ **Sex:** _____ **Age:**_____ **Date of Birth**_____/___/____

*****Students, please makes sure your name, sex, age, and date of birth before giving to the physician. Failure to do so will cause you to have an incomplete physical. *****

This Section Is For The Physician Only!

- ☐ 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 pre-participation physical evaluation. The athlete does not present apparent clinical contradictions 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/guardian).

Name of physician (print/type):_____ Date:_____

Address:_____ Phone:_____

Signature of physician:_____ MD or DO

Students Should Complete This Section By Following The Directions.

Emergency Information

Allergies (If you do not have allergies simply put "N/A" on the line) _____

_____

_____

_____

_____

_____

_____

_____

Other Information (If you do not have any other information simply put "N/A" on the line)_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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: _____