

ARC Cheerleading Tryout Information

The Academy of Richmond County strives to build the best cheerleading program with squads that excel in academics, support for ARC athletic teams, and school spirit.

Tryout Dates:

- April 24-27 : mandatory tryout practices 4:30-6:30. Bring completed application packet to Ms. Scoggins on or before April 17.
- April 27: tryout 4:30-until finished

What to expect at tryouts:

You will be taught cheers, one dance, the fight song, and jumps. Stunting and tumbling will not be taught at tryouts. There will not be people available for spotting. When you perform your tumbling for the actual tryout, you cannot have a spot.

Tryout Procedure:

- Mandatory tryout practices will be held in the ARC Gym. Roll will be taken.
- Shorts, shirts, and athletic shoes must be worn at all times. NO JEWELRY!
- Shirt must not have printing on it
- Hair must be pulled back away from face
- You must be ready to begin practice at 4:30! Promptness everyday will be expected.

Applicants will be judged on the following skills:

- Multiple cheers
- Dance routine
- Fight Song
- Jumps (toe touch , any other jump, combo jump)
- Flyers - Heel stretch both sides,
- Tumbling
 - Tumbling will be observed on each of the three tryout days
- Strength
- Endurance

Duties and Requirements:

1. The student must be passing his/ her classes in order to be eligible to cheer.
2. Any cheerleader who breaks school rules may also receive consequences within the squad and may be dismissed.
3. If disciplinary actions not covered in policies are necessary they will be decided upon by the cheerleading coach and the school administration.
4. Any unscheduled practice will be announced at least one day ahead of time. **Any absence without prior approval by the coach will result in an unexcused absence.**
5. Doctor's appointments, unless emergencies, should not be scheduled for practice or game days.
6. All cheerleaders must attend all games including tournament and playoff games. **We sometimes have games on non school days.**
7. Cheerleaders are expected to be at the stadium one hour before the game starts, unless otherwise stated by the coach.
8. All members will travel outside the Richmond County area as a unit.
9. You must be counted present for at least ½ day on game days or you will not be allowed to cheer that night. You must dress out and sit with the coach if you are not counted present for ½ the school day.
10. If you lose or damage any part of your uniform you are responsible for immediate replacement.
11. All cheerleaders must participate in fundraisers.

The only concessions that will be made during tryout week will be for academic reasons and spring sports participants. Keeping this in mind, please do not commit to other events that may conflict with tryouts. Please give serious thought to any other obligation you already have. If these require out-of-town engagements or conflict with practices, it may be necessary to make a choice.

We sincerely hope to continue traditions set by previous squads while improving the quality of the program. If you have any questions, please contact Coach Scoggins scoggka@boe.richmond.k12.ga.us. Thanks for your interest in the ARC Cheerleading Program.

Signature of parent or guardian: _____ Date: _____

Signature of student: _____ Date: _____

CHECKLIST

Please be sure all of the following have been completed by the due date, April 17

- Information Sheet (signed)
- Checklist (signed)
- Application Sheet
- Student/ Parent Concussion Awareness Form (Must be signed and dated)
- Parent Permission Form (Must be signed and dated)
- Athlete Roster
- Copy of Insurance Card
- Contact Information Form
- Copy of Current Physical (Must be signed and dated)
- Clearance Form (Must be signed and dated)
- Copy of most recent report card
- 7 Teacher Recommendations (returned by the teacher by April 17th)

***Failure to complete any one of the above items by April 17 will result in the inability of the applicant to participate in clinics or tryouts.*

I agree that this packet includes all the above completed items.

Student Signature

Date

Application Sheet

Student Information

Name: _____ Upcoming grade: _____
Current School: _____

Basic Information

1. Why are you interested in trying out for cheerleading?

2. List three attributes you can contribute to the team.

3. What fundraising ideas do you have for the **Cheerleading** Team? Would you be willing and available to participate in all fundraisers as they may take place during the week and weekends?

4. What experience do you have with cheerleading? Are you on a competitive cheerleading squad?

5. Do you have experience with stunting? What position do you want?

6. Can you tumble? What is your highest level or ability in tumbling?

7. How will you get home from practices and games?

8. Are you involved with any other activities or sports after school? If yes, please list activities, and corresponding days of practices.

9. Are you prepared to represent the Richmond County School District, Academy of Richmond County, staff, faculty, students, and surrounding community in a responsible, respectful, and professional manner?

10. What else do you want us to know about you?

I have read the rules, expectations and all the information on the application is correct.

Student Signature _____

Georgia High School Association 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.

By signing this concussion form, I give _____ High School permission to transfer this concussion form to the other sports that my child may play. I am aware of the dangers of concussion and this signed concussion form will represent myself and my child during the 2016-2017 school year. This form will be stored with the athletic physical form and other accompanying forms required by the _____ School System.

I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.

Student Name (Printed)

Student Name (Signed)

Date

Parent Name (Printed)

Parent Name (Signed)

Date

**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: _____ Signature: _____
(Parent/Legal Guardian)

Date: _____ Signature: _____
(Parent/Legal Guardian)

ATHLETE ROSTER

Sport: _____

Name: _____ Birthdate: _____

Sex: [M] [F] Grade: [] [] []

Address: _____

Home Phone # : _____

Name of Parent/Guardian: _____

Address if different from above: _____

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

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

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

Name: _____ Relation: _____

Address: _____

Phone # : (H) _____ (B) _____

FAMILY PHYSICIAN INFORMATION:

Physician Name: _____ Speciality: _____

Address/Location: _____

Phone # : (Office) _____ (Emergency) _____

INSURANCE COMPANY INFORMATION:

Primary: _____ Policy # : _____

Secondary: _____ Policy # : _____

Specific medication, allergies, medical problems of the athlete:

Contact Information

Cheerleader's Name: _____

Cheerleader's cell phone number (best form of communication): _____

Cheerleader's email: _____

I live with (circle all that apply)

Mother

Father

Step Mother

Step Father

Other

Parent/Guardian Name: _____

Work Number: _____

Cell phone: _____

Text Do Not Text (circle one)

Email: _____

Parent/Guardian Name: _____

Work Number: _____

Cell phone: _____

Text Do Not Text (circle one)

Email: _____

Form of transportation (circle all that apply) Carpool Driver Car rider

Any comments or concerns about transportation that I need to know:

List any medical concerns that I should know:

Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam _____

Name _____ Sex _____ Age _____ Date of birth _____
 Grade _____ School _____ Sport(s) _____
 Address _____ Phone _____
 Personal Physician _____
In case of emergency, contact:
 Name _____ Relationship _____ Phone (H) _____ Phone (W) _____

**Explain "Yes" answers below.
Circle questions you don't know the answers to.**

		Yes	No			Yes	No	
1.	Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	24.	Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25.	Is there anyone in your family who has asthma?	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	<input type="checkbox"/>	<input type="checkbox"/>	26.	Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	<input type="checkbox"/>	<input type="checkbox"/>	27.	Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28.	Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>	
6.	Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29.	Do you have any rashes, pressure sores, or other skin problems?	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	30.	Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>	
8.	Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31.	Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>	
9.	Has a doctor ever told you that you have (check all that apply):			32.	Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> High blood pressure			33.	Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> A heart murmur			34.	Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> High cholesterol			35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/> A heart infection			36.	Have you ever been unable to move your arms or legs after being hit or falling?	<input type="checkbox"/>	<input type="checkbox"/>	
10.	Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	<input type="checkbox"/>	<input type="checkbox"/>	37.	When exercising in the heat, do you have severe muscle cramps or become ill?	<input type="checkbox"/>	<input type="checkbox"/>	
11.	Has anyone in your family died for no apparent reason?	<input type="checkbox"/>	<input type="checkbox"/>	38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	<input type="checkbox"/>	<input type="checkbox"/>	
12.	Does anyone in your family have a heart problem?	<input type="checkbox"/>	<input type="checkbox"/>	39.	Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	
13.	Has any family member or relative died of heart problems or of sudden death before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	40.	Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	
14.	Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	41.	Do you wear protective eyewear, such as goggles or a face shield?	<input type="checkbox"/>	<input type="checkbox"/>	
15.	Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	42.	Are you happy with your weight?	<input type="checkbox"/>	<input type="checkbox"/>	
16.	Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	43.	Are you trying to gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>	
17.	Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	<input type="checkbox"/>	<input type="checkbox"/>	44.	Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>	
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	45.	Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>	
19.	Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	<input type="checkbox"/>	<input type="checkbox"/>	46.	Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest	
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes	
20.	Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	FEMALES ONLY				<input type="checkbox"/>
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	<input type="checkbox"/>	<input type="checkbox"/>	47.	Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>	
22.	Do you regularly use a brace or assistive device?	<input type="checkbox"/>	<input type="checkbox"/>	48.	How old were you when you had your first menstrual period?	_____		
23.	Has a doctor ever told you that you have asthma or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	49.	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 _____

Preparticipation Physical Evaluation

PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP _____ / _____ (____ / _____, ____ / ____)

Vision R 20/ _____ L 20/ _____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only.

+Having a third party present is recommended for the genitourinary examination.

Notes: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation

CLEARANCE FORM

Name _____ Sex _____ Age _____ Date of birth _____

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: _____

Not Cleared for All sports Certain sports: _____ Reason: _____

Recommendations: _____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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Student Name: _____ **Grade:** ____ **Teacher:** _____ **Subject:** _____

Students should have the top filled out for you. Please take a minute to rank the characters and abilities of the above student. **Rank "0" as the lowest and "5" as the highest.** Thank you for taking the time to complete this by **April 17th**. Please return it to **Ms. Scoggins** or to the **ARC front office (middle schools)**. Teachers may email this recommendation to scoggka@boe.richmond.k12.ga.us. **Please do not return to the student.**

1. Is this student respectful? _____
2. Is this student attentive in class? _____
3. How well does this student interact with others? _____
4. Is the student capable of balancing cheer & academics? _____
5. Does this student show pride/spirit for the school? _____
6. Does this student finish class work / homework? _____
7. Does this student come prepared for class? _____
8. Is this student tardy and/or absent from class often? _____

Rate student's overall behavior _____

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Sign up for important updates from Ms. Scoggins.

Get information for Academy Of Richmond County High School right on your phone—not on handouts.

Pick a way to receive messages for **ARC 2016-2017 Cheerleading Tryouts**:

A If you have a smartphone, get push notifications.

On your iPhone or Android phone, open your web browser and go to the following link:

rmd.at/arctryouts

Follow the instructions to sign up for Remind. You'll be prompted to download the mobile app.



B If you don't have a smartphone, get text notifications.

Text the message @arctryouts to the number 81010.

If you're having trouble with 81010, try texting @arctryouts to (404) 620-6603.

** Standard text message rates apply.*



Don't have a mobile phone? Go to rmd.at/arctryouts on a desktop computer to sign up for email notifications.