PLEASE RETURN COMPLETED FORMS TO YOUR COACH PRIOR TO THE START OF ANY SPORT PHYSICAL ACTIVITY

Dear Parent / Guardian:
Enclosed you will find the Pre-Participation Physical Evaluation form and necessary documentation that is required of all students trying out and/or participating in a school sport during the current school year. The Pre-Participation Physical Evaluation is a screening to ensure that your child is medically eligible for participation in accordance to the Georgia High School Association guidelines. The physical will be valid for 1 calendar year. If your child will be participating in any school sport(s), please completely fill out this packet making sure you AND your student-athlete sign and date where asked.

The following are included:

- Athlete Roster (must include Insurance information)
- Parent Permission for Student Athletic Participation
- RCBOE Interscholastic Contract for Parents and Student-Athletes
- GHSA Student/Parent Concussion Awareness Form
- GHSA Student/Parent Sudden Cardiac Arrest Awareness Form
- GHSA Heat and Humidity Guidelines
- Authorization to Disclose Health Information
- Permission to Treat/Acknowledgement of Risk
- Emergency Medial Card (must include Insurance information)
- Awareness of Football Risk (football athletes only)
- Pre-participation Physical Evaluation

It is extremely important that this packet is completed, signed by you and the student-athlete, and **returned to the coach of the sport you are playing**, prior to the participation in any school sport activity. Incomplete information or missing signatures could delay your child from participation. All physical packets are due before the first day of practice of your child's sport. If the packet is not turned in by that time, your child will not be cleared to practice or play until the forms are completed and returned.

If you have any questions, please feel free to contact:

Kevin Scheyer, Academy of Richmond County Athletic Director
scheyke@boe.richmond.k12.ga.us

Thank you for your cooperation.
We look forward to working with you and your student-athlete this coming school year.

ON ON ARC

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#: (Home) _____ **(Business)** _____

FAMILY PHSICIAN INFORMATION:

Physician Name: _____ **Specialty:** _____

Address: _____

_____

Phone #: (Office) _____ **(Emergency)** _____

INSURANCE COMPANY INFORMATION:

Primary: _____ **Policy #:** _____

Secondary: _____ **Policy #:** _____

Specific medication, allergies, medical problems of the athlete:

_____

_____

PARENT PERMISSION
FOR STUDENT ATHLETIC PARTICIPATION

Dear Parent(s) or Guardians(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 School System that all athletic participants provide either proof of insurance or purchase the student accident insurance policy that is sanctioned by the Board. 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 thos 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. Parent/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)

Richmond County School System
Learning today...Leading tomorrow

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

1. I 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 the 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 _____ school year.

This contract becomes effective this _____ day of _____ 20_____.

_____

Signature of parent or guardian Print Name

_____

Signature of student Print Name

REVISED JULY 2023

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 2023-2024 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***

(Revised: 3/23)

Georgia High School Association
Student/Parent Sudden Cardiac Arrest Awareness Form

SCHOOL: _____

1: Learn the Early Warning Signs

If you or your child has had one or more of these signs, see your primary care physician:

- Fainting suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones
- Unusual chest pain or shortness of breath during exercise
- Family members who had sudden, unexplained and unexpected death before age 50
- Family members who have been diagnosed with a condition that can cause sudden cardiac death, such as hypertrophic cardiomyopathy (HCM) or Long QT syndrome
- A seizure suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones

2: Learn to Recognize Sudden Cardiac Arrest

If you see someone collapse, assume he has experienced sudden cardiac arrest and respond quickly. This victim will be unresponsive, gasping or not breathing normally, and may have some jerking (Seizure like activity). Send for help and start CPR. You cannot hurt him.

3: Learn Hands-Only CPR

Effective CPR saves lives by circulating blood to the brain and other vital organs until rescue teams arrive. It is one of the most important life skills you can learn – and it's easier than ever.

- Call 911 (or ask bystanders to call 911 and get an AED)
- Push hard and fast in the center of the chest. Kneel at the victim's side, place your hands on the lower half of the breastbone, one on top of the other, elbows straight and locked. Push down 2 inches, then up 2 inches, at a rate of 100 times/minute, to the beat of the song "Stayin' Alive."
- If an Automated External Defibrillator (AED) is available, open it and follow the voice prompts. It will lead you step-by-step through the process, and will never shock a victim that does not need a shock.

By signing this sudden cardiac arrest form, I give _____ High Schoo permission to transfer this sudden cardiac arrest form to the other sports that my child may play. I am aware of the danger of sudden cardiac arrest and this signed sudden cardiac arrest form will represent myself and my child during the 2023-202 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***

(Revised: 3/23)

2.67 **Practice Policy for Heat and Humidity**:

(a) Schools must follow the statewide policy for conducting practices and voluntary conditioning workouts (this policy is year-round, including during the summer) in all sports during times of extremely high heat and/or humidity that will be signed by each head coach at the beginning of each season and distributed to all players and their parents or guardians. The policy shall follow modified guidelines of the American College of Sports Medicine in regard to:
   (1) The scheduling of practices at various heat/humidity levels.
   (2) The ratio of workout time to time allotted for rest and hydration at various heat/humidity levels.
   (3) The heat/humidity levels that will result in practice being terminated.

(b) A scientifically-approved instrument that measures the Wet Bulb Globe Temperature must be utilized at each practice to ensure that the written policy is being followed properly. WBGT readings should be taken every hour, beginning 30 minutes before the beginning of practice.

WBGT	ACTIVITY GUIDELINES AND REST BREAK GUIDELINES
Under 82.0	Normal Activities - Provide at least three separate rest breaks each hour with a minimum duration of 3 minutes each during the workout.
82.0 - 86.9	Use discretion for intense or prolonged exercise; watch at-risk players carefully. Provide at least three separate rest breaks each hour with a minimum duration of 4 minutes each.
87.0 - 89.9	Maximum practice time is 2 hours. For Football: players are restricted to helmet, shoulder pads, and shorts during practice, and all protective equipment must be removed during conditioning activities. If the WBGT rises to this level **during** practice, players may continue to work out wearing football pants without changing to shorts. For All Sports: Provide at least four separate rest breaks each hour with a minimum duration of 4 minutes each.
90.0 - 92.0	Maximum practice time is 1 hour. For Football: no protective equipment may be worn during practice, and there may be no conditioning activities. For All Sports: There must be 20 minutes of rest breaks distributed throughout the hour of practice.
Over 92.0	No outdoor workouts. Delay practice until a cooler WBGT level is reached.

(c) Practices are defined as: the period of time that a participant engages in a coach-supervised, school-approved sport or conditioning-related activity. Practices are timed from the time the players report to the practice or workout area until players leave that area. If a practice is interrupted for a weather-related reason, the "clock" on that practice will stop and will begin again when the practice resumes.

(d) Conditioning activities include such things as weight training, wind-sprints, timed runs for distance, etc., and may be a part of the practice time or included in "voluntary workouts."

(e) A walk-through is not a part of the practice time regulation, and may last no longer than one hour. This activity may not include conditioning activities or contact drills. No protective equipment may be worn during a walk-through, and no full-speed drills may be held.

(f) Rest breaks may not be combined with any other type of activity and players must be given unlimited access to hydration. These breaks must be held in a "cool zone" where players are out of direct sunlight.

(g) When the WBGT reading is over 86, ice towels and spray bottles filled with ice water should be available at the "cool zone" to aid the cooling process AND cold immersion tubs must be available for the benefit of any player showing early signs of heat illness. In the event of a serious EHI, the principle of "Cool First, Transport Second" should be utilized and implemented by the first medical provider onsite until cooling is completed (core temperature of 103 or less).

Head Coach's Signature _____ Date _____

Athletes Name _____ Parent Signature _____ Date _____

Authorization to Disclose Health Information

Athlete's Name: _____ Date of Birth: _____

I authorize AU Medical Center, Inc. to use or disclose the above named individual's health information as described below, concerning the period from July 1, 2023 to June 30, 2024.

_ Medical information, as specified:
_ Standard Document Set (Discharge Summary, History and Physical, Progress Notes, Test Results, Consults)
X Other (specify): **Pre-Participation Exam and any subsequent athletic injury or condition**
_ Entire Medical Record (justification required)
_ Psychiatric/Psychological Information
_ Drug/Alcohol Abuse Treatment Information
_ HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome)

This information may be disclosed to and used by the following individual or organization (circle ONE):

Name: Academy of Richmond County
Address: 910 Russell St., Augusta, GA 30904

Name: Butler High School
Address: 2011 Lumpkin Rd., Augusta, GA 30906

Name: Cross Creek High School
Address: 3855 Old Waynesboro Rd., Augusta, GA 30906

Name: Davidson Fine Arts Magnet School
Address: 615 12th St., Augusta, GA 30901

Name: Glenn Hills High School
Address: 2840 Glenn Hills Dr., Augusta, GA 30906

Name: Hephzibah High School
Address: 4558 Brothersville Rd., Hephzibah, GA 30815

Name: T.W. Josey High School
Address: 1701 15th St., Augusta, GA 30901

Name: Lucy C. Laney High School
Address: 1339 Laney Walker Blvd., Augusta, GA 30901

Name: RCTCM School
Address: 3200B Augusta Tech Drive, Augusta, GA 30906

Name: Westside High School
Address: 1002 Patriot's Way, Augusta, GA 30907

Name: AR Johnson Health Science & Engineering Magnet School
Address: 1324 Laney Walker Blvd, Augusta, GA 30901

Purpose: To assist the coaches, school administration, and Richmond County Board of Education with the athlete's ability to participate in athletics

Special Instructions: Only coaches from the particular sport or Athletic Director, School Administration may receive this information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: **06/30/24**. If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Health Information Management Services at (706) 721-2722.

_____ _____
Parent or Legal Representative Signature Date

_____ _____
If signed by Legal Representative, Relationship to Athlete Signature of Witness

PERMISSION TO TREAT/ACKNOWLEDGEMENT OF RISK FORM

Participating in interscholastic athletic activities/sports has the potential to be harmful to all participants. The parent/guardian and student-athlete understands that participating in these activities increases the risk for bodily injury and possibly sudden death. Participation in interscholastic athletic activities/sports is strictly voluntary, and the parent/guardian hereby assumes responsibility for any and all injuries and other loses that the student-athlete may suffer through participation. If you are unwilling to assume these risks your minor student-athlete will not be eligible to participate in interscholastic athletic activities/sports as part of the Richmond County Board of Education School District.

Parental consent for minor athletes is generally required for sports medicine services, defined as services including, but not limited to, evaluation, diagnosis, first-aid and emergency care, stabilization, treatment, rehabilitation and referral of injuries and illnesses, along with decisions on return-to-play after injury or illness. Occasionally, those minor athletes require sports medicine services before, during and after their participation in sport-related activities, and under circumstances in which a parent or legal guardian is not immediately available to provide consent pertaining to the specific condition affecting the athlete. In such instances it may be imperative to the health and safety of those athletes that sports medicine services necessary to prevent harm be provided immediately, and not be withheld or delayed because of problems obtaining consent of a parent/guardian.

Accordingly, in their relationship with AU Health – Jaguar Sports Medicine, the Richmond County Board of Education requires as a pre-condition of participation in interscholastic activities, that a parent/guardian provide written consent to the rendering of necessary sports medicine services to their minor athlete by a qualified medical provider (QMP) employed or otherwise designated by the school/district, to the extent the QMP deems necessary to prevent harm to the student-athlete. It is understood that a QMP may be an athletic trainer, physician, physician assistant, or nurse practitioner licensed by the state of Georgia (or the state in which the student-athlete is located at the time the injury/illness occurs), and who is acting in accordance within the scope of practice under their designated state license and any other requirement imposed by Georgia law. In emergency situations, the QMP may also be a credentialed paramedic or emergency medical technician, but only for the purpose of providing emergency care and transport as designated by state regulation and standing protocols, and not for the purpose of making decisions about return to play.

I, _____, am the parent/guardian of _____,
a minor and student-athlete participating in interscholastic athletic activities/sports as part of the Richmond County Board of Education School District.

I understand that the school/district employs or designates QMP's (as defined above) to provide sports medicine services (as also defined above) to the school's interscholastic student-athletes before, during, or after sport-related activities, and that on certain occasions there are sport-related activities conducted away from the school/district facilities during which other QMP's are responsible for providing such sports medicine services. I hereby give consent to any such QMP to provide any such sports medicine services to the above-named minor. The QMP may make decisions on return-to-play in accordance within the defined scope-of-practice under the designated state license, except as otherwise limited by Georgia law. I also understand that documentation pertaining to any sports medicine services provided to the above-named minor, may be maintained by the QMP. I hereby authorize the QMP who provides such services to the above-named minor to disclose such information about the athlete's injury/illness, assessment, condition, treatment, rehabilitation and return-to-play status to those who, in the professional judgment of the QMP, are required to have such information in order to assure optimum treatment for and recovery from the injury/illness, and to protect the health and safety of the minor. I understand such disclosures may be made to above-named minor's coaches, athletic director, school nurse, any classroom teacher required to provide academic accommodation to assure the student-athlete's recovery and safe return to activity, and any treating QMP.

If the parent/guardian believes that the minor is in need of further treatment or rehabilitation services for the injury/illness, the minor may be treated by the QMP or a provider of the parent's/guardian's choice. I understand, however, that all decisions regarding same day return-to-activity following injury/illness shall be made by the QMP employed/designated by the school/district.

Student-Athlete's Name (printed)	Student-Athlete's Signature	Date
Parent's/Guardian's Name (printed)	Parent's/Guardian's Signature	Date

Emergency Medical Card

Student name: _____ Date of Birth: ___ / ___ / _____

Name of Parent/Guardian: _____

Cell Phone #: _____ Home/Work Phone #: _____

Name of Physician: _____ Phone: _____

Name of Insurance Company: _____ Policy #: _____

Preferred Medical Facility: _____

Allergies: Yes ___ No ___ Type: _____

List medications: _____

Richmond County Board of Education

Awareness of Football Risk

The coaches in our football program are well qualified, professionals that emphasize the proper fundamentals related to playing the game of football. Regardless of this fact, football being a contact sport, injuries will occur. It is the purpose of this handout to inform the player and the parent of this and make them aware of the safety precautions that must be adhered to in order to prevent or minimize injuries.

By rule the helmet is not to be used as a "ram." It is not possible to play the game safely or correctly without making some contact with the helmet when properly blocking and tackling, but proper technique would be for the initial contact to be made with the shoulder. In addition, the head should never be bent downward when making contact. If the head is bent downward on contact or if the contact is on the top of the helmet, serious injury could occur; including joint dislocation, nerve damage, paralysis, or even death.

Rules also prohibit a player from blocking below the waist outside a two by four-yard area next to the football. This is an important rule which was made to help minimize the number of serious knee and ankle injuries.

It is important that the uniform, especially the helmet and shoulder pads, fit properly. All players should have some basic knowledge of the correct fitting uniform. Shoulder pads that are too small will leave the shoulder point vulnerable to bruises or separations. If they are too tight in the neck area, a pinched nerve could result. Shoulder pads that are too large will leave the neck area vulnerable and will slide on the shoulders, once again making them vulnerable to bruises and separations.

Helmets must fit snugly at the contact points: front, back, and top of the head. Each helmet must be "NOCSAE" branded for safety and a warning sticker must be visible. On contact, a helmet too tightly fitting helmet could produce a headache. One fitting too loosely could produce headaches, concussions, face injuries such as broken noses or cheek bones, or a serious neck injury. No player should practice until both he and the coach are satisfied with the fit of the helmet.

This handout does not cover all possible injuries while playing football, but it is an effort to make both the players and parents aware of the fact that proper techniques, adhering to the rules of the game, and properly fitting equipment are vital to each player's safety and enjoyment of the game.

We understand the information presented and are aware of the risks involved in playing football. We also understand that the player must accept a major role in the prevention of serious injuries by adhering to the rules, by using proper technique, and by using properly fitted equipment.

Athlete's Signature _____

Parent's Signature _____ Date _____

Richmond County School System

Learning today... Leading tomorrow

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____
(First Name) (Last Name)

Date of examination: _____ Sport(s): _____

Sex assigned at birth: _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

*Over the last 2 weeks, how often have you been bothered by any of the following problems? **(check box next to appropriate number)***

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	☐0	☐1	☐2	☐3
Not being able to stop or control worrying	☐0	☐1	☐2	☐3
Little interest or pleasure in doing things	☐0	☐1	☐2	☐3
Feeling down, depressed, or hopeless	☐0	☐1	☐2	☐3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

(First Name)

(Last Name)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?	☐	☐
2. Has a provider ever denied or restricted your participation in sports for any reason?	☐	☐
3. Do you have any ongoing medical issues or recent illness?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?	☐	☐
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	☐	☐
7. Has a doctor ever told you that you have any heart problems?	☐	☐
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	☐	☐

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	☐	☐
10. Have you ever had a seizure?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	☐	☐
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	☐	☐
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	☐	☐

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	☐	☐
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	☐	☐
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐	☐
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	☐	☐
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?	☐	☐
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	☐	☐
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	☐	☐
22. Have you ever become ill while exercising in the heat?	☐	☐
23. Do you or does someone in your family have sickle cell trait or disease?	☐	☐
24. Have you ever had or do you have any problems with your eyes or vision?	☐	☐

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?	☐	☐
26. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
27. Are you on a special diet or do you avoid certain types of foods or food groups?	☐	☐
28. Have you ever had an eating disorder?	☐	☐

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

2023 This form has been modified for use by the GHSA

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____
(First Name) (Last Name)

PHYSICIAN 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, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 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 performance-enhancing 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 a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	☐	
Eyes, ears, nose, and throat • Pupils equal • Hearing	☐	
Lymph nodes	☐	
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	☐	
Lungs	☐	
Abdomen	☐	
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis	☐	
Neurological	☐	
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck	☐	
Back	☐	
Shoulder and arm	☐	
Elbow and forearm	☐	
Wrist, hand, and fingers	☐	
Hip and thigh	☐	
Knee	☐	
Leg and ankle	☐	
Foot and toes	☐	
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test	☐	

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____