# HALL COUNTY SCHOOL DISTRICT ATHLETIC REGISTRATION

**PLEASE PRINT ALL INFORMATION:**

**NAME OF SCHOOL: ________________________________________________**

**Name of Student: _____________________________________Grade: _______**

**Name(s) of Parent or Guardian: ___________________________________________**

**Home Phone Number: ______________Emergency Phone Number: _____________**

## PARENTAL CONSENT FOR ATHLETIC PARTICIPATION

**WARNING:** Although participation in supervised interscholastic athletics may be one of the least hazardous in which students will engage in or out of school, by its nature participation in interscholastic athletics includes a risk of injury which may range in severity from minor to long term catastrophic. Although serious injuries are not common in supervised school athletic programs, it is possible only to minimize, not eliminate, the risk.

Participants have the responsibility to help reduce the risk 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 _________________________________________to:

(1) Compete in interscholastic athletics at ____________________________School of the Hall County School District in Georgia High School Association (GHSA) sports, **except those CROSSED OUT** below:

| | | | |
|---|---|---|---|
| Baseball | Cross Country | Soccer | Track & Field |
| Basketball | Football | Softball | Volleyball |
| Cheerleading | Golf | Tennis | Wrestling |

(2) To accompany any school team of which the student is a member on any of its local or out-of-town trips;
(3) And, I hereby verify that the information on both sides of this form is correct and understand that any false information may result in my son/daughter being declared ineligible.

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): ________________________________**

**DATE: ___________________**

**SIGNATURE OF STUDENT-ATHLETE: ___________________________________________**

**DATE: ___________________**

## INSURANCE INFORMATION

Please INITIAL one of the following statements regarding insurance coverage for your student-athlete for the ____________ school year, then sign below.

____ My student-athlete is adequately and currently covered by accident insurance that will cover injuries sustained while participating in interscholastic athletics, including, but not limited to varsity and junior varsity football.

Company providing insurance: ___________________________________
Name of Insured: _______________________________________________
Policy Number: ________________________________________________

____ I wish to purchase the Benefit Plan provided by the Hall County School System. (A signed copy of this Benefit Plan should be stapled to this form.)

**As a parent (guardian) of the above-named student-athlete, I understand that unless I have insurance, or have purchased school insurance, there is no school district insurance which may cover any injuries, loses, or damages arising out of my child's participation in the activities previously indicated.**

**SIGNATURE(S) OF PARENT(S) OR GUARDIAN(S):** _____________________________

**DATE:** ________________________

## DRUG-TESTING ADMINSTRATION ACKNOWLEDGEMENT/CONSENT FORM

The Hall County Board of Education has authorized mandatory random drug tests for all student-athletes who participate in Georgia High School Association (GHSA) inter-scholastic athletics. Any sports activity that requires an annual physical as a condition of participation is subject to this procedure.

1. The student-athlete must present to the head coach this signed consent form, which authorizes the school to administer drug testing and that allows the results of the test to be released to parents or guardians, administrative officials, and the head coach. **(Note: A signed consent form is a requirement for participation in any GHSA governed inter-scholastic activity that requires an annual physical examination for participation. Parents and students do not have the option of not participating in the drug-screen program.)**
2. Random testing will take place at any time during the season with student-athletes chosen through lottery/random selection. Testing consists of providing a urine sample to those representatives of the firm administering the test. School personnel will supervise but will not administer the test. Privacy will be protected. Specimens will be processed for identity and secured to ensure against tampering. Test results will be reported to the school through the proper chain of command. In case of a positive result, the parent or guardian will be notified.

Testing will be done by the Northeast Georgia Forensic/Toxicology Lab under the supervision of the Toxicology Program Manager.

This acknowledgement of administration and consent to allow participation in the random drug-testing program shall remain in effect until revoked in writing.

**SIGNATURE(S) OF PARENT(S) OR GUARDIAN(S):** ___________________________________

**DATE:** ____________________

**SIGNATURE OF STUDENT-ATHLETE:** ______________________________________________

**DATE:** ___________________

## GHSA BY-LAW 2.67 – "Practice Policy for Heat and Humidity

Schools must follow the statewide policy for conducting practices and voluntary conditioning workouts 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 level that will result in practice being terminated

A scientifically approved instrument that measures Wet Bulb Globe Temperature (WBGT) reading must be utilized at each practice to ensure that the written policy is being followed properly.

| **WBGT READING** | **ACTIVITY GUIDELINES & REST BREAK GUIDELINES** |
|---|---|
| **UNDER 82.0** | Normal activities --Provide at least three separate rest breaks each hour of minimum duration of 3 minutes each during 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 of a minimum of four minutes duration each. |
| **87.0 – 89.9** | Maximum practice time is two hours. For Football: players restricted to helmet, shoulder pads, and shorts during practice. All protective equipment must be removed for conditioning activities. For all sports: Provide at least four separate rest breaks each hour of a minimum of four minutes each. |
| **90.0--92.0** | Maximum length of practice is one hour, no protective equipment may be worn during practice and there may be no conditioning activities. There must be 20 minutes of rest breaks provided during the hour of practice. |
| **OVER 92** | No outdoor workouts; Cancel exercise; delay practices until a cooler WBGT reading occurs |

**GUIDELINES FOR HYDRATION AND REST BREAKS**

1. Rest time should involve both unlimited hydration intake (water or electrolyte drinks) and rest without any activity involved
2. For football, helmets should be removed during rest time
3. The site of the rest time should be a "cooling zone" and not in direct sunlight.
4. When the WBGT reading is over 86:

a. ice towels and spray bottles filled with ice water should be available at the "cooling zone" to aid the cooling process.

b. Cold immersion tubs must be available for practices for the benefit of any player showing early signs of heat illness.

**DEFINITIONS**

1. **PRACTICE:** 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 field until they leave.

2. **WALK THROUGH*:*** this period of time shall last no more than one hour, is not considered to be a part of the practice time regulation, and may not involve conditioning or weight-room activities. Players may not wear protective equipment.

**PENALTIES:** Schools violating the heat policy shall be fined a minimum of $500.00 and a maximum of $1,000.00.

Head Coach's Signature verifying a copy of the above GHSA By-Law 2.67 has been provided to the parent(s)/guardian(s) of the player registered:

_________________________________________ Date: _________________________

Parent/Guardian Signature verifying having been given a copy of GHSA By-Law 2.67:

__________________________________________ Date: __________________________

# PREPARTICIPATION PHYSICAL EVALUATION
# HISTORY FORM

*(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep 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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ____________ | | |
| 3. Have you ever spent the night in the hospital? | | |
| 4. Have you ever had surgery? | | |
| **HEART HEALTH QUESTIONS ABOUT YOU** | **Yes** | **No** |
| 5. Have you ever passed out or nearly passed out DURING or AFTER exercise? | | |
| 6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? | | |
| 7. Does your heart ever race or skip beats (irregular beats) during exercise? | | |
| 8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ____________ | | |
| 9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram) | | |
| 10. Do you get lightheaded or feel more short of breath than expected during exercise? | | |
| 11. Have you ever had an unexplained seizure? | | |
| 12. Do you get more tired or short of breath more quickly than your friends during exercise? | | |
| **HEART HEALTH QUESTIONS ABOUT YOUR FAMILY** | **Yes** | **No** |
| 13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)? | | |
| 14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? | | |
| 15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? | | |
| 16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? | | |
| **BONE AND JOINT QUESTIONS** | **Yes** | **No** |
| 17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game? | | |
| 18. Have you ever had any broken or fractured bones or dislocated joints? | | |
| 19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? | | |
| 20. Have you ever had a stress fracture? | | |
| 21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) | | |
| 22. Do you regularly use a brace, orthotics, or other assistive device? | | |
| 23. Do you have a bone, muscle, or joint injury that bothers you? | | |
| 24. Do any of your joints become painful, swollen, feel warm, or look red? | | |
| 25. Do you have any history of juvenile arthritis or connective tissue disease? | | |

| MEDICAL QUESTIONS | Yes | No |
|---|---|---|
| 26. Do you cough, wheeze, or have difficulty breathing during or after exercise? | | |
| 27. Have you ever used an inhaler or taken asthma medicine? | | |
| 28. Is there anyone in your family who has asthma? | | |
| 29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? | | |
| 30. Do you have groin pain or a painful bulge or hernia in the groin area? | | |
| 31. Have you had infectious mononucleosis (mono) within the last month? | | |
| 32. Do you have any rashes, pressure sores, or other skin problems? | | |
| 33. Have you had a herpes or MRSA skin infection? | | |
| 34. Have you ever had a head injury or concussion? | | |
| 35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? | | |
| 36. Do you have a history of seizure disorder? | | |
| 37. Do you have headaches with exercise? | | |
| 38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | | |
| 39. Have you ever been unable to move your arms or legs after being hit or falling? | | |
| 40. Have you ever become ill while exercising in the heat? | | |
| 41. Do you get frequent muscle cramps when exercising? | | |
| 42. Do you or someone in your family have sickle cell trait or disease? | | |
| 43. Have you had any problems with your eyes or vision? | | |
| 44. Have you had any eye injuries? | | |
| 45. 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. How old were you when you had your first menstrual period? | | |
| 54. How many periods have you had in the last 12 months? | | |

**Explain "yes" answers here**

____________________

____________________

____________________

____________________

____________________

____________________

____________________

____________________

____________________

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date ____________

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# Preparticipation Physical Evaluation

# THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ______________________________

Name ______________________________ Date of birth ______________

Sex ______ Age ______ Grade ______ School ______________ Sport(s) ______________

| |
|---|
| 1. Type of disability |
| 2. Date of disability |
| 3. Classification (if available) |
| 4. Cause of disability (birth, disease, accident/trauma, other) |
| 5. List the sports you are interested in playing |

| | Yes | No |
|---|---|---|
| 6. Do you regularly use a brace, assistive device, or prosthetic? | | |
| 7. Do you use any special brace or assistive device for sports? | | |
| 8. Do you have any rashes, pressure sores, or any other skin problems? | | |
| 9. Do you have a hearing loss? Do you use a hearing aid? | | |
| 10. Do you have a visual impairment? | | |
| 11. Do you use any special devices for bowel or bladder function? | | |
| 12. Do you have burning or discomfort when urinating? | | |
| 13. Have you had autonomic dysreflexia? | | |
| 14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness? | | |
| 15. Do you have muscle spasticity? | | |
| 16. Do you have frequent seizures that cannot be controlled by medication? | | |

**Explain "yes" answers here**

______________________________

______________________________

______________________________

______________________________

______________________________

**Please indicate if you have ever had any of the following.**

| | Yes | No |
|---|---|---|
| Atlantoaxial instability | | |
| X-ray evaluation for atlantoaxial instability | | |
| Dislocated joints (more than one) | | |
| Easy bleeding | | |
| Enlarged spleen | | |
| Hepatitis | | |
| Osteopenia or osteoporosis | | |
| Difficulty controlling bowel | | |
| Difficulty controlling bladder | | |
| Numbness or tingling in arms or hands | | |
| Numbness or tingling in legs or feet | | |
| Weakness in arms or hands | | |
| Weakness in legs or feet | | |
| Recent change in coordination | | |
| Recent change in ability to walk | | |
| Spina bifida | | |
| Latex allergy | | |

**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 ______________

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# PREPARTICIPATION PHYSICAL EVALUATION
# PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

## 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, 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 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 (questions 5–14).

| **EXAMINATION** | | |
|---|---|---|
| Height Weight ☐ Male ☐ Female | | |
| BP / ( / ) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N | | |
| **MEDICAL** | **NORMAL** | **ABNORMAL FINDINGS** |
| Appearance<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | |
| Eyes/ears/nose/throat<br>• Pupils equal<br>• Hearing | | |
| Lymph nodes | | |
| Heart[a]<br>• Murmurs (auscultation standing, supine, +/- Valsalva)<br>• Location of point of maximal impulse (PMI) | | |
| Pulses<br>• Simultaneous femoral and radial pulses | | |
| Lungs | | |
| Abdomen | | |
| Genitourinary (males only)[b] | | |
| Skin<br>• HSV, lesions suggestive of MRSA, tinea corporis | | |
| Neurologic[c] | | |
| **MUSCULOSKELETAL** | | |
| Neck | | |
| Back | | |
| Shoulder/arm | | |
| Elbow/forearm | | |
| Wrist/hand/fingers | | |
| Hip/thigh | | |
| Knee | | |
| Leg/ankle | | |
| Foot/toes | | |
| Functional<br>• Duck-walk, single leg hop | | |

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________________

______________________________

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports ______________________________

Reason ______________________________

Recommendations ______________________________

______________________________

**I have examined the above-named student and completed the 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

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HE0503 9-2681/0410

# ■ Preparticipation Physical Evaluation
# 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 ______________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

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Northeast Georgia
PHYSICIANS GROUP

# Authorization to Disclose Health Information

Patient's Name: ___________________________ Date of Birth: _____________

**I authorize Northeast Georgia Physicians Group Sports Medicine to use or disclose the above named individual's health information as described below, concerning the period from 4/01/2013 to 3/31/2014.**

Medical information, as specified:

**X** Other (specify): **Pre-Participation Exam and any subsequent athletic injury**

**This information may be disclosed to and used by the following individual or organization:**

**Name**: Athletic Department and School Administration at West Hall High School
**Address:** 5500 McEver Road
Oakwood, GA 30566

**Name**: Hall County Board Of Education
**Address**: 711 Green Street
Gainesville, GA 30506

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

**Special Instructions**: Only coaches from the particular sport or Athletics Director, School Administration and Hall County Board of Education 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: **3/31/2014**. 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.

_______________________________ Student Signature

_______________ Date

_______________________________ Parent or Legal Representative Signature

_______________ Date

_______________________________ If signed by Legal Representative, Relationship to Athlete

_______________ Signature of Witness