PRE-PARTICIPATION PHYSICAL EVALUATION HISTORY FORM

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

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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PHYSICAL EXAMINATION FORM

Name: ______________________ Date of Birth: ______________

PHYSICIAN REMINDERS

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?

Consider reviewing questions on cardiovascular symptoms (5–14).

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 [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) [b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • 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 concussions.

☐ Cleared for all sports without restriction

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

☐ Not cleared

- Pending further evaluation
- For any sports
- For certain sports

Reason__________ Recommendation__________

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present any apparent limitations to practice and participate in the sport(s) as outlined above. 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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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 pre-participation physical evaluation. The athlete does not have any apparent clinical reasons to limit practice or participation in the sport(s) as outlined above. A copy of the physical exam is on record and can be made available to the school at the request of the parents. If conditions of concern arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem has been resolved and the potential consequences are explained to the athlete (and parents/guardians).

Name of Physician (Print)______________________________ Date __________

Address______________________________

Phone ______________ Signature of Physician______________________________, MD or DO

EMERGENCY INFORMATION

Allergies

____

____

____

____

____

____

Other Information

____

____

____

____

PRE-PARTICIPATION PHYSICAL EVALUATION HISTORY FORM-SPECIAL NEEDS

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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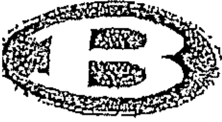
BRYAN COUNTY BOARD OF EDUCATION



BRYAN COUNTY HIGH SCHOOL
Parental Consent and Insurance Information Form

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

Students can and do have the responsibility to reduce the chance of injury. STUDENTS AND PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO TEACHERS/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 permission for my (our) child, ______________________________, to:

1. Compete in all athletics at Bryan County High School under the Georgia High School Association except ______________________________.
2. Accompany any school team/activity on any local or out-of-town trips.
3. I hereby verify that the information on this form is correct and understand that any false information may result in my son/daughter being declared ineligible for participation.
4. I consent to Internet storage and delivery of this information to medical providers as appropriate.

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

My child has the following medical condition(s) of which healthcare providers should be aware:

Condition(s): ______________________________

Allergies (food, bee stings, medications): ______________________________

Current medications taken: ______________________________

<u>Insurance Information (please check one and complete)</u>

Emergency contact name: ____________________ relationship ____________ phone ____________

Family physician ____________________ phone ____________

☐ My son/daughter is adequately and currently covered by accident insurance that will cover injuries sustained while participating in any school-authorized activity. *(Please furnish copy of current card.)*

____

Company providing insurance   Name of insured   policy/group number

☐ My son/daughter is <u>not</u> currently covered by accident insurance. *(<u>Proof of insurance coverage is required before participation is permitted.</u>)*

______________________________   ____________

Student signature   *date*

______________________________   ____________

Signature of Person authorized to Consent for Student (parent or legal guardian)   *date*

______________________________   ____________

Relationship to student   *witness*

DON'T FORGET

TO ATTACH A COPY

OF YOUR

<u>INSURANCE</u>

<u>CARD!!!!!</u>

APPENDIX A- BCS PARTICIPATION PACKET

AUTHORIZATION FOR EXCHANGE OF HEALTH AND EDUCATION INFORMATION

(The Health Insurance Portability and Accountability Act - HIPAA)

Bryan County Schools
8810 Hwy 280 East
Black Creek, Georgia 31308
912-851-4000

Student Information

Student Name:____

Address:____

Male________Female_________ Date of Birth: ____________________

Parent/Guardian:____________________________________

Phone: (H)____________________(W)__________________(C)________________

Parental Consent

I hereby authorize ____________________________________

(Name of Local Education Agency)

and ________________________ ________________ ________________

(Physicians Name) *(Title)* *(Phone Number)*

and ____ ________________________

(Primary Insurance Company) *(Policy Number)*

to exchange health and education information/ records for the purposes listed below.

Description

The health information to be disclosed consists of the following:

____

____

Authorization

This authorization is valid for one year or as specified:________________________

It will expire on:____

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the local education agency (LEA), may no longer be protected by HIPPA, but they will become education records protected by the Family Educational Rights and Privacy Act (FERPA).

Parent/Guardian Signature:____________________________ Date:________________

STUDENT RELEASE FORM:

For Field Trips, Athletic Events and Other Activities Requiring System Transportation

I, as parent, custodian, or guardian of the below named minor, hereby release the Bryan County Board of Education, its employees and agents from any and all claims I may assert against such because of my child's participation in an off-campus event. This release shall act as a release of all claims that may occur at the event as well as all claims that may arise because of travel to and from the event.

SCHOOL: ______________________________

CHILD'S NAME: ______________________________

PARENT'S NAME: ______________________________

PERSON(S) TO BE CONTACTED IN CASE OF EMERGENCY:

NAME: ______________________ PHONE NUMBER: ______________

NAME: ______________________ PHONE NUMBER: ______________

INSURANCE INFORMATION

Policy (Company) Name ______________________ Policy/Group Number: ______________

Name of Insured ______________________________

MEDICAL INFORMATION

The following information will be provided to EMS personnel, physician(s), and other health care personnel as needed in the event your child needs assistance and you cannot be located.
I/We, the parent(s) of ______________, hereby give EMS personnel, physician(s) and other health care personnel permission to render medical treatment to the child in case of illness or injury.
I further authorize you to transport the child to ______________________ hospital and enter the care of the family physician ______________, whose phone number is ______________.
If the family physician cannot be contacted, I authorize the emergency room physician to treat the child. I hereby release the Bryan County Board of Education and its employees and agents from all claims arising from such treatment or care.

MY CHILD HAS THE FOLLOWING MEDICAL CONDITIONS: ______________________

MY CHILD HAS AN ALLERGY TO THE FOLLOWING MEDICATION(S): ______________________

MY CHILD IS TAKING THE FOLLOWING MEDICATION(S): ______________________

____

Parent/Guardian Signature

NONDISCRIMINATION STATEMENT

It is the policy of the Bryan County Board of Education not to discriminate on the basis of sex, age, race, handicap, disability, religion, or nationality in the educational programs and activities or in admissions to facilities operated by the Bryan County Board of Education or in the employment practices of the Bryan County School System. The Bryan County Board of Education complies with all aspects of Title IX of the Education Amendments of 1972, Title VI of the Civil Rights Act of 1964 (Amended, 1973), Title II of Vocational Education Amendments of1976, Title VII of the Civil Rights Act of 1964(Amended, 1974), Title XXIX of age Discrimination, Act of 1967, Section S04 of the Rehabilitation Act of 1973, and the Americans With Disabilities Act.

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STUDENT/PARENT CONCUSSION AWARENESS FORM

SCHOOL NAME:____

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 activity. 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 symptoms, as well as increased risk for further injury to the brain.

Player and parental education in concussion policies is crucial. This form must be signed by the parent or guardian of each student who wishes to participate in GHSA athletics. One copy needs to be returned to the school, and one may be kept 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
- 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 healthcare professional has determined that no concussion has occurred. (NOTE: An appropriate healthcare professional may include: a 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 director 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 by an appropriate healthcare professional prior to resuming participation in any 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.

d) Each school will be responsible for monitoring the participation of its coaches in the concussion management course.

I HAVE READ THIS FORM AND I UNDERSTAND THE INFORMATION PRESENTED.

SIGNED:____________________________ (Student)

____________________________ (Parent or Guardian)

DATE:____________________________

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STUDENT/PARENT GHSA HEAT AND HUMIDITY AWARENESS FORM

Dangers of Heat and Humidity

Over the years, more and more cases of heat-related illness have occurred. It has resulted in a number of side effects including cramping, stroke, and even death. Certain sports are at higher risk than others, especially when considering equipment needs for safety (Football, Lacrosse, etc.). Heat illness is highly preventable, however, and extreme caution must be taken in order to protect our student athletes. Humidity plays an important role in our bodies' ability to dissipate heat. As the humidity rises, so do the risks to our health.

Player and parent education is essential to preventing heat exhaustion. Please read over the following information. This form must be reviewed and signed by **BOTH** the **parent/guardian** and the **student athlete** who wishes to participate in GHSA and RHHS Athletics.

Common Signs and Symptoms of Heat Illness

Headache	Chills	Pallor or flush	Nausea	Weak, rapid pulse
Incoherent	Vomiting	Cramping	Unusual fatigue/lightheadedness	

GHSA By-Law 2.67 - Practice Policy for Heat and Humidity:

(a) 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. This policy will be signed by each head coach at the beginning of the 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 regards to:
(1) The scheduling of practices at various heat/humidity levels
(2) The ratio of workout time to breaks 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 start of practice.

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

WET BULB GLOBE TEMPERATURE (WBGT) ACTIVITY GUIDELINES

- **Under 82.0** - Normal Activities. Provide at least three breaks each hour with a minimum duration of 3 minutes each.
- **82.0 - 86.9** - Use discretion for intense or prolonged exercise; watch at-risk players carefully. Provide at least three breaks each hour with a minimum duration of 4 minutes each.
- **87.0 – 89** - 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 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 92.1** - No outdoor workouts. Delay practice until a cooler WBGT level is reached.

I HAVE READ THIS FORM AND I UNDERSTAND THE INFORMATION PRESENTED.

ATHLETE SIGNATURE:____________________ **Date:**__________

PARENT/GUARDIAN SIGNATURE:____________________ **Date:**__________

optimhealthcare

Doctor Led, Patient Focused

MEDICAL CONSENT TO TREAT

The undersigned grants the representative from Optim Sports Medicine Center and its employee's parental consent for your child's pre-participation screening and assessment/treatment of your child's injuries that he/she may suffer during the school year.

I give permission for the school official, chaperone, or representative of the Optim Sports Medicine Center, involved in the activity with my child, to seek medical aid, render first aid if such attention is necessary in the sole discretion of said person involved. In case of emergency and when I cannot be immediately reached by telephone or otherwise, I give permission to the physician selected by the school officials to hospitalize, secure proper treatment, and order injections, anesthesia, or surgery for my child. I agree to be responsible for all medical expenses incurred in connection therewith. In the event the School incurs expenses for medical treatment, then and in that event I agree to reimburse said institution in full.

THE UNDERSIGNED CERTIFIES THAT HE/SHE READ AND UNDERSTANDS THE ABOVE.

______________________________ ____________________

Parent/Guardian Signature **Date**

CONSENT FOR A PRE-PARTICIPATION EVALUATION (PPE)

(*Must be signed if participating in Optim-provided Spring Physicals*)

I hereby authorize and consent to having Optim Sports Medicine Center. Athletic Trainers and/or their consulting physician(s) perform a Pre-Participation Evaluation (PPE) on me for the _____-_____school year. I understand that this PPE is a health screening and is not intended to take the place of the physical exam that can be performed by a physician. I understand that the scope of this PPE (medical history, blood pressure/pulse screen, and heart/lung auscultation) WILL NOT IDENTIFY many of the medical problems known to be associated with sudden death in athletes. Some of those medical problems include but are not necessarily limited to cardiac abnormalities, pulmonary abnormalities, aneurysms, and/or sickle cell trait.

I hereby fully and forever release and discharge Optim Sports Medicine Center., its subsidiaries and affiliated corporations, and their respective directors, trustees, officers, employees and agents and my physician(s) or any other person participating in my care from any and all claims, demands, damages, rights of acting or causes of action, present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the completion of this PPE.

I understand that this PPE is being carried out with my consent and so assume full responsibility for the limitations of this PPE in detecting many of the health problems associated with sudden death in athletes.

______________________________ ____________________

Parent/Guardian Signature **Date**

Please complete/sign/date every line (if applicable) in order for your student athlete to be eligible to participate.

APPENDIX B: DUAL ATHLETE PARTICIPATION FORM

It is the intention of the athlete named below to participate in two sports during one season. In order for this to occur, the following stipulations must be met:

1. The process must be initiated by a scheduled conference with the athletic director.

2. The athlete must declare which sport is primary and which secondary for participation purposes.

3. Approval may be denied because of academic concerns at any time during the sport season. The athlete will then participate in the primary sport only.

4. Practice and Game/Meet requirements must be established prior to the start of the sport season. Contests take precedence over practice, and the primary sport contests take precedence over secondary sport contests. This should be detailed in writing below after a conference between the athletic director and the coaches involved.

Name of Athlete: ______________________________ Sports: ___________________________

Primary Sport: ____________________

Practice and Game/Meet Requirements (Attached):

Additional Stipulations (Attached):

Coach Signature (primary)	**Date**	**Parent Signature**	**Date**
Coach Signature (secondary)	**Date**		
AD Signature	**Date**	**Athlete Signature**	**Date**