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: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

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.)

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?	☐	☐
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?	☐	☐
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

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: _____

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, 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: _____

_____

_____

THOMASVILLE CITY SCHOOLS
ATHLETIC DEPARTMENT

TRAVEL PERMISSION FORM

I hereby give my permission for my son/daughter _____ to go on planned trips associated with his/her participation and as a member of the _____ team.

I understand that these trips will be under the supervision of an employee of the Thomasville City School System. By execution of this parent permission slip, the undersigned acknowledges that the proposed trips will be so supervised but may occur at indoor/outdoor locations other than the properties owned by the Thomasville City Schools and may expose participants to non-school environments and to the actions of non-school personnel, which are beyond the control of the Thomasville City Schools. The undersigned further acknowledges that these trips may involve motor vehicle travel away from school premises and that the method of transportation is at the discretion of the Thomasville City Schools. Student-competitors may not drive their own vehicles to events.

The student-competitor will be expected to travel with his/her team throughout the entire competitive season as stipulated by the coach/sponsor.

It will be the decision of the head coach/sponsor of that particular sport/activity or sponsor of the sport/activity whether a student may be released from traveling to or from the school. For a student to be granted permission to travel other than with his/her group or team, the parent/guardian must give each coach a written request prior to that particular activity.

If the coach does agree to release the student to return with parent/guardian, the parent/guardian must personally see the head coach/sponsor at the time the student is to be released.

The undersigned hereby releases, individually and as a parent and guardian of his/her participating child, the Thomasville City Schools, Thomasville City Schools Board of Education and any and all employees of same liability for death, personal injury, and/or property damage that maybe sustained by the above referenced student while involved in this travel and related activities.

_____ _____

Parent Signature Date

THOMASVILLE CITY SCHOOLS
ATHLETIC DEPARTMENT
INHERENT RISK

We would like to take this opportunity to further inform you of the risk of injury while participating in athletics. There is an inherent risk of injury for all sports. You need to be aware of the fact that even the best coaching, the use of the most advanced protective equipment, and strict observance of the rules, injuries can be so severe as to result in total disability, paralysis, or even death. In summary, we take every precaution possible to prevent athletic injuries, but we also realize that using the best prevention methods can not eliminate all injuries. We always hope for an injury free season for all our student-athletes in the Thomasville City Schools System. We assure you that in an event of an injury your son/daughter will be given the best possible treatment, care and rehabilitation of that injury.

EXPLANATION OF INSURANCE COVERAGE

We want to take this opportunity to explain that in order to participate in athletics for the Thomasville City Schools, your child must be covered by either an accident insurance or personal insurance. The Thomasville High School athletic program utilizes the sports medicine program at Archbold Sports Medicine for an athlete's injuries. Any injury that occurs during a practice or game will be referred to the high school Athletic Trainer. The Athletic Trainer will then assess the injury and suggest appropriate treatment and/or recommend a visit to a specialized physician. We encourage all athletes and their parents to adhere to this policy to avoid unneeded medical expenses. If an athlete does receive medical attention, the cost of the treatment is the responsibility of the parent(s) and/or their health insurance. The Thomasville City Schools offers accident coverage through South Georgia Benefits Consultants located in Thomasville, Georgia.

EARLY RELEASE

From time to time, we must leave school with athletic teams before the school day is completed. When these situations arise, your child's name will appear on a roster that will be given to the attendance office and their teachers as to inform them of the absence. Athletes on trips with their team will not be counted absent; rather they will be coded for a field trip. The athlete is responsible for any and all work missed. The athletic department is aware of the importance of education so these occasions are kept to the bare minimum.

ARREST POLICY

Students are expected to abide by a behavior that goes above and beyond that of the average student as they serve in an ambassadorial role in our community. Those athletes that are arrested for a felony will be suspended from athletic participation until the case is dispensed.

THOMASVILLE CITY SCHOOLS
ATHLETIC DEPARTMENT
Parental Consent for Emergency Medical Treatment

The purpose of this document is to give my consent for emergency medical treatment and transportation of my minor child. Students Athlete's name: _____ Grade_____. I UNDERSTAND THAT IN THE EVENT OF SERIOUS INJURY OR SUDDEN ILLNESS OCCURING TO MY CHILD, EVERY PRUDENT EFFORT WILL BE MADE BY THE SCHOOL AND/OR MEDICAL OFFICIAL TO CONTACT ME. IF I CANNOT BE CONTACTED, THIS DOCUMENT (OR PHOTOCOPY) WILL SERVE AS MY PARENTAL OR GUARDIANSHIP CONSENT.
I give my permission to the health care providers of the TCS Sports Medicine team (Physicians, ATC's, and Nurses, medical personnel, Archbold rehabilitation, and hospital staff) to perform physical examinations and treatments of sports related injuries. I understand by signing this form, I am authorizing them to treat my child for as long as they deem necessary and appropriate or until I withdraw my consent in writing.

In Emergency: Contact_____

Phone: _____**Secondary Phone:** _____

General Information about Student Athlete

Date of Birth: _____

Address_____

_____

Allergies: Daily Medications and reason for being taken

_____

_____

Relevant Medical information: Diabetes, major injuries, surgeries, contact lenses, epilepsy, heart murmurs, etc.

_____

_____

I, as guardian of _____, understand all of the above policies. I agree to allow him/her to participate in interscholastic sports in the Thomasville City Schools. I understand that sports have an inherent risk of injury and that my insurance will be used in the event of an injury. I know that my child may on occasions have to leave school early and he/she will be responsible for all work missed. I also understand and agree that my child should be held to a higher standard of behavior because of the role in the community. I will make every effort to encourage my child to behave in a manner that represents the school and the community well. I understand the policy regarding arrest and will abide by all decisions and policies of the Athletic Department.

Parents or Guardian's Signature: _____

Date: _____

THOMASVILLE CITY SCHOOLS
ATHLETIC DEPARTMENT

SCHOOL YEAR:_____

Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone: _____

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

Home Phone: _____ Work: _____ Cell: _____

Home Phone: _____ Work: _____ Cell: _____

In Case of Emergency, notify:
Name Phone Number(s)

_____

_____

(Insurance Co. and Policy Holder must be filled in.)
(Either Group Number or ID Number or both must be filled in.)

Family Physician: _____ Phone: _____

Insurance Co.: _____ Policy Holder: _____

Group Number: _____ ID Number: _____

List Allergies: _____

Any Health Problems: _____

Parent/Guardian: _____ Date: _____

I fully understand that my child cannot participate in athletics in the Thomasville City School System unless covered by either school accident insurance or personal insurance.

THOMASVILLE CITY SCHOOLS
ATHLETIC DEPARTMENT

Mandatory Extracurricular Drug Testing Program

Consent to Perform Urinalysis

All students involved in extra-curricular activities at Thomasville High School must agree to make themselves available for random drug testing. The test used will be a urinalysis. An outside party is responsible for all parts of the drug testing. For a first violation, the student athlete and his or her parents/guardians will be required to attend a specified amount of counseling with a program approved by the District. The student shall be required to comply with any recommendations resulting from the assessment/counseling as part of the assessment. To deter the student from committing a subsequent violation of this policy, the student will be subject to an unannounced random drug test/screening and will be added to the list of those tested in the next round of testing/screening. A student testing positive for a second violation, he/she will lose 20% of his/her participation in all inter-scholastic competition (rounded up to the nearest whole number). The student must participate in an approved drug counseling program. Once a student has a third subsequent positive drug test, he/she shall be prohibited from participation from all inter-scholastic competitions for one (1) full calendar year form the date of the positive test. The full policy and procedure is on file in the Athletic Director's office.

I have read and understand the policy and procedures for the Thomasville City Schools Drug Testing Program for students involved in extracurricular activities and hereby give my consent for my son/daughter to participate in the appropriate urinalysis-testing program conducted by the contracted agency chosen by Thomasville City Schools.

_____ _____

Student Signature **Parent/Guardian Signature**

_____ _____

Date **Date**

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 2020-2021 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: 2/20)

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 School permission to transfer this sudden cardiac arrest form to the other sports that my child may play. I am aware of the dangers of sudden cardiac arrest and this signed sudden cardiac arrest form will represent myself and my child during the 2020-2021 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: 2/20)