WEST HALL MIDDLE SCHOOL ATHLETIC PARTICIPATION FORM

ALL HIGHLIGHTED AREAS MUST BE COMPLETED PRIOR TO STUDENT PARTICIPATION IN ATHLETICS

Last Name ______________ First Name ______________ MI ______ Grade ______ Student No. ______

CONTACT INFORMATION

Student Name: ____ **9th Gr. Entry Date:** _______________

Home Address: ____ **City:** ________________________

Name of Parent/Guardian(s): ____

Address (if different from above): ____ **City:** ___________________

Mother: (Home Phone): (_____) _______-_______________ (Cell): (______) ________-_______________

Father: (Home Phone): (______) _______-_______________ (Cell): (_____) ________-________________

IN CASE OF EMERGENCY, CONTACT:

Name: ____ **Relationship:** _________________________

(Home) (_______) ________-________________) (Cell) (_____) ________-_______________________

Personal Physician: ____ **Phone:** ___________________________

ALTERNATIVE TRANSPORTATION LIABILITY RELEASE

Initial:_______ Hall County Schools/West Hall School is not always able to provide transportation for students to off campus extra-curricular school activities. In cases when transportation is not provided by Hall County Schools/WHHS, as in the use of a school bus or charter bus, it is the responsibility of the student's parents/guardian to secure their student's attendance at such activities. Hall County Schools, its local schools, officers, employees or agents shall not be responsible for any injury or loss arising out of a student's transportation to or from the off campus activity when such transportation is provided by parents, student, staff or any other party.

MEDIA RELEASE

Initial:_______ I hereby give my consent to all photographs, audio recordings, academic work and/or video recordings taken of me or my minor child by Hall County Schools' staff or their designee. I understand that any such photographs, audio recordings, academic work and/or video recordings become the property of the local school or district and may be used by the school, district or others within their consent, for educational, instructional or promotional purposes determined by the district in broadcast and electronic media formats now existing or in the future created.

PARENTAL CONSENT FOR ATHLETIC PARTICIPATION

Initial:_______ **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	Cheerleading	Football	Soccer	Tennis	Volleyball
Basketball	Cross Country	Golf	Softball	Track & Field	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.

PERMISSION TO TREAT

Initial: ______ I give my permission for the coaches, certified trainers and/or their designees to administer treatment for illness, injury, or rehabilitation.

Initial: ______ In the event of an emergency and I cannot be reached, I grant permission to school personnel, coaches and/or certified athletic trainers to activate the Emergency Action Plan.

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

Date of Exam____ Sport(s):______________________________________

Name:____ Date of Birth:_______________________ _____________

Sex ___________ Age _____________ Grade ___________ School ____________________________ _______________

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	**Yes**	**No**
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 /CLEARANCE 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 seatbelt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight □ Male □Female		
BP / (/) Pulse Vision R20/ L20/ 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 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 participation 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 parent. 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/stamp) ______________________________ **Phone** ______________________________

Street Address______________________________ **City** ____________________ **State** ________ **Zip** ______________

Signature of Physician: ______________________________**,MD or DO** **Date of Exam**: ______________________

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HE0503

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: ___________

Insurance Information

Please **INITIAL ONE** of the following statements regarding insurance coverage for your son/daughter for the _________ school year.

_______ My son/daughter is adequately and currently covered by accident insurance that will cover injuries sustained while participating in interscholastic athletes (including, but not limited to, varsity and junior varsity football).

________________________________ ______________________________ ____________________________

Company providing insurance: **Name of insured:** **Policy#:**

OR

______ I wish to purchase the Benefit Plan provided for the Hall County School System. (**A signed copy of this Benefit Plan must 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.**

MEDICAL AUTHORIZATION

I certify that the medical history on this form is complete and accurate. I understand that this will serve as the basis for determining that my child, ______________________________, may compete in high school athletics in Hall County Schools. I also understand that this medical evaluation is only to determine fitness for athletics and is not to take the place of regular medical examinations. In case of an emergency or accident on the school grounds or during any school activity involving my child, _____________________________, which in the opinion of school authorities present requires immediate medical or surgical attention, I hereby grant permission to physicians, consulting physicians, athletic trainers, emergency medical technicians, and other healthcare providers selected by school authorities to provide medical care and treatment (including hospitalization if deemed appropriate by school authorities or an appropriate healthcare provider) unless I am present and request otherwise or until I later request otherwise.

PLEASE SIGN HERE:

THIS SIGNATURE CONSENTS TO TRANSPORTATION LIABILITY, MEDIA RELEASE, DRUG TESTING, PERMISSION TO TREAT, ATHLETIC PARTICIPATION, VERIFICATION OF INSURANCE COVERAGE AND MEDICAL AUTHORIZATION. THIS SIGNATURE ALSO REPRESENTS THAT ALL INFORMATION PROVIDED IN THIS ATHLETIC PARTICIPATION FORM IS ACCURATE AND COMPLETE.

______________________________ ______________________________________ _____________

SIGNATURE OF ATHLETE **SIGNATURE OF PARENT/GUARDIAN** **DATE**