

## ■ 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  $\geq 3$  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 <i>Staphylococcus aureus</i> (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.**

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**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

- 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?
- Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
BP: _____ / _____ ( _____ / _____ )	Pulse: _____	Vision: R 20/ _____ L 20/ _____ Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>		
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 <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>		

<sup>a</sup> 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: \_\_\_\_\_

\_\_\_\_\_

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

1. Type of disability:		
2. Date of disability:		
3. Classification (if available):		
4. Cause of disability (birth, disease, injury, or other):		
5. List the sports you are playing:		
	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or 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 as having 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.**

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**Please indicate whether you have ever had any of the following conditions:**

	Yes	No
Atlantoaxial instability		
Radiographic (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.**

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**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: \_\_\_\_\_





CHEROKEE COUNTY SCHOOL DISTRICT  
Athletic Parental Consent, Insurance, Authorization and Waiver and Release Form  
2022-23 School Year



MEDICAL COVERAGE INFORMATION

Please INITIAL one of the following statements regarding medical coverage for your student for the current school year, then sign below.

My student is adequately and currently covered by accident insurance/medical coverage that will cover injuries sustained while participating in any school authorized activity (including, but not limited to Varsity or JV Football).

Insurance Company/Medical Coverage Provider	Name of Insured	Policy Number
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I have purchased the Benefit Plan provided by CCSD. I understand this is a supplemental policy. (A copy of this Benefit Plan should be attached)

Signature(s) Parent(s)/Guardian(s)	Date
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AUTHORIZATION AND WAIVER

I/We certify that the medical history on this form is complete and accurate. I/We understand that this will serve as the basis for determining that my student may compete in middle/high school athletics within CCSD. I/We also understand this medical evaluation is general in nature and only performed to determine fitness for athletics and is not to take place of regular medical examinations. In case of an emergency or accident on/off school grounds during any school activity or athletic event, which in the opinion of school authorities present requires immediate medical or surgical attention, I/we hereby grant permission to physicians, consulting physicians, certified athletic trainers, emergency medical technicians, and other healthcare providers selected by school authorities to provide medical care and treatment (including hospitalization if deemed necessary) unless I am present and request otherwise or until I later request otherwise.

I/We understand that the terms hereof apply to any injury, illness or other medical problem or emergency that arises as a result of or in connection with any aspect of athletic participation for CCSD, including tryouts, practice, conditioning, meetings, games, and/or travel. I/We also understand that reasonable efforts will be made to contact parent(s) or legal guardian(s) before any serious or involved medical treatment.

I/We understand that per GHSA, a Pre-Participation Physical Evaluation must be performed by a physician to medically screen each student who participates in the athletic program(s) of CCSD. I/We further understand that a basic medical screening (the required physical exam) is general in nature and limited in its scope and does not indicate or assure me that my student is completely free from impairments. If I/we wish for a more detailed physical exam to be performed upon my student, then it is my responsibility to arrange and pay for such an exam. If this more detailed exam is performed, it is my responsibility to notify CCSD and its appropriate employees, of any potential medical problems uncovered by any physical exam given to my student other than the general physical required by the school system for athletic participation.

I/We assume all liability and responsibility for any and all potential or real risks, injuries or even death which may result from Student's participation in inter-scholastic athletics, sports teams/clubs and events. I/We represent and warrant that I/we know of no mental or physical condition that would make it unsafe for Student to participate in inter-scholastic athletics, sports teams/clubs and events. I/We understand, acknowledge and agree that CCSD shall not be liable for any injury/illness suffered by the Student which arises out of and/or is associated with preparing for and/or participating in inter-scholastic athletics, sports teams/clubs and events.

I/We understand that certain athletic events and practices may be video recorded and that the video recording may contain (my)(your student's) image and voice. I/We understand and authorize the use of the video recordings by coaches, athletic directors, public information officials and third parties to improve individual and team performance, to promote (my)(my Student's) school or the District's athletic program, to share information about (me)(my student) or team with the public, and to promote and showcase (my)(my Student's) skills and athletic achievement with college recruiters and third parties that may assist in college recruitment. The School District currently utilizes HUDL® to analyze video, track stats, manage feedback, and create highlights in one easy-to-use online platform. HUDL® in conjunction with you/your parents/guardians and coaches shares its analytics and highlights with college recruiters around the Country. By signing below you/We agree to 1) allow the recording of my/you student's image and voice 2) allow the release of (my)(your student's) image, voice, and analytics as described above 3) allow the storage and unsecure transmission of (my)(my student's) image, voice and analytics by the School District and third parties such as HUDL® 4) allow HUDL® and its partners to utilize Personally Identifiable Information (PII) routinely collected in accordance with the HUDL® Terms of Use and Privacy Policy (<https://www.hudl.com/terms> and <https://www.hudl.com/privacy>). I/We understand that the Children's Online Privacy Protection Act (COPPA) in some instances requires Verifiable Parental Consent to allow the collection and use of PII as is contemplated by HUDL®. By signing below, I/We represent and warrant that I/We are the legal parents/guardians of the student whose name appears above and presently possesses the legal authority to consent to the uses of my/our PII as contemplated by HUDL®. I/We further release the School District and its employees, agents, and School Board from any and all liability or responsibility regarding the release of the information described in this paragraph.

I/We hereby release, discharge, indemnify, and agree to hold harmless CCSD, Members of the CCSD Board of Education, its past, present and future officers, attorneys, agents, employees, predecessors and successors in interest, and assigns, hereinafter "CCSD Releasees", from any and all liability arising out of or in connection with Student's participation in inter-scholastic athletics, sports team/clubs and events. For purpose of this Release, liability means all claims, demands, losses, causes of action, suits, or judgements of any kind that Student or Student's parents, guardians, heirs, executors, administrators, and assigns have or may have against the CCSD Releasees because of Student's personal, physical, or emotional injury, accident, illness or death, or because



CHEROKEE COUNTY SCHOOL DISTRICT  
Athletic Parental Consent, Insurance, Authorization and Waiver and Release Form  
2022-23 School Year



of any loss of or damage to property that occurs to Student or his or her property including Student's participation in inter-scholastic athletics, sports teams/clubs and events due to acts of passive or active negligence by CCSD Releasees other than actions involving fraud or actual malice.

By signing below, I/we acknowledge that I/we have carefully read this voluntary Waiver and understand the potential dangers incident to engaging in inter-scholastic athletics, sports teams/clubs and events, and are fully aware of the legal consequences of this agreement.

Signature(s) Parent(s)/Guardian(s)	Date
Signature of Student	Date

THIS ACKNOWLEDGEMENT OF AUTHORIZATION AND WAIVER SHALL REMAIN IN EFFECT UNTIL REVOKED IN WRITING.

Signature(s) Parent(s)/Guardian(s)	Date
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STUDENT TRANSPORTATION RELEASE AND CONSENT FORM

While CCSD provides transportation through the utilization of the District bus fleet for many extracurricular events, in some cases school sponsored transportation is not available. In those instances, it is necessary for the parent/guardian to make arrangements for transportation. CCSD discourages students from riding with other students to and from extracurricular events.

I/We, \_\_\_\_\_, parent/guardian of \_\_\_\_\_ (student) hereby give my/our permission for my student to provide his/her own transportation to/from extracurricular events, and I/we, parent/guardian of the student listed above, hereby give my permission for my/our student to ride with another parent.

I/We hereby consent on behalf of the student named to participate in school-sponsored trips. I/We understand that transportation may or may not be provided by CCSD. In the event transportation is not provided by CCSD, transportation will be the student's and parent(s)/guardian(s) responsibility.

Signature(s) Parent(s)/Guardian(s)	Date
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RELEASE OF INFORMATION TO MEDIA AND COLLEGES

I/We hereby authorize the release of any and all information relating to the athletic participation of the above-named student to the media and to all college recruiters, including any medical information concerning injury or illness, any biographical information, and any other information related to the athletic participation, including ability, attitude and conduct.

Signature(s) Parent(s)/Guardian(s)	Date
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GUIDELINES FOR OUTDOOR EXTRACURRICULAR ACTIVITIES DURING EXTREME HOT AND HUMID WEATHER

I/We hereby verify that I/we have received and reviewed the CCSD Guidelines for Outdoor Extracurricular Activities During Extreme Hot and Humid Weather.

Signature(s) Parent(s)/Guardian(s)	Date
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CHEROKEE COUNTY SCHOOL DISTRICT  
Athletic Parental Consent, Insurance, Authorization and Waiver and Release Form  
2022-23 School Year



STUDENT ATHLETE CONCUSSION AWARENESS, DIAGNOSIS AND MANAGEMENT PROGRAM  
*(GHSAA 02.18)*

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.

COMMONS 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/we 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 2022-23 school year. This form will be stored with the athletic physical form and other accompanying forms required by CCSD.

I/We have read the information concerning usage of the Immediate Post-Concussion Assessment and Cognitive Test (ImPACT™) and understand its contents. I/We have been given an opportunity to ask questions and all have been answered to my satisfaction. I/We understand that participation in the ImPACT™ concussion baseline testing is highly recommended but not required for athletes in Cherokee County schools. I/We also understand that the ImPACT™ testing is merely a tool to assist Medical Professionals in the diagnosis and subsequent treatment of potentially serious injuries, the ImPACT™ testing IS NOT a substitute for treatment by a Medical Professional.

I/We acknowledge that if my/our child is suspected of receiving a concussion causing injury, my/our child WILL NOT be allowed to participate in athletics until cleared by an appropriate health care provider. (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.)

Please INITIAL one of the choices below, sign and date:

\_\_\_\_\_ YES, I give permission for my child, \_\_\_\_\_, to participate in baseline training with the ImPACT™ program.

\_\_\_\_\_ NO, I do not give permission for my child, \_\_\_\_\_, to participate in baseline testing.

\_\_\_\_\_  
Signature(s) Parent(s)/Guardian(s)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date