

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> 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 _____

■ PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

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

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

Explain "yes" answers here

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

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, 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 (questions 5–14).

EXAMINATION		
Height _____	Weight _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP _____ / _____ (_____ / _____)	Pulse _____	Vision R 20/ _____ L 20/ _____ Corrected <input type="checkbox"/> Y <input type="checkbox"/> 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		

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

- Not cleared
- Pending further evaluation
- For any sports
- For certain sports _____
- Reason _____

Recommendations _____

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

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

■ PREPARTICIPATION PHYSICAL EVALUATION CLEARANCE FORM

Name _____ Sex M F Age _____ Date of birth _____

Cleared for all sports without restriction

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

Not cleared

Pending further evaluation

For any sports

For certain sports _____

Reason _____

Recommendations _____

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

Name of physician (print/type) _____ Date _____

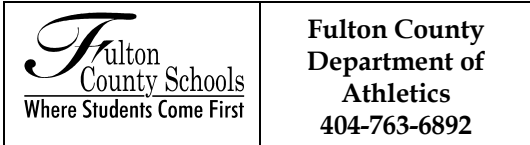
Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____



**STUDENT'S APPLICATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS
AND VERIFICATION OF SUBSTITUTE INSURANCE**

This form is to be completed by the Parent/Guardian and Student prior to the first practice session. It contains vital information in case of injury or an emergency situation. Coaches are to ensure that this form accompany this athlete to all practices and contests. Please print all information. Parent(s) / Guardian(s) acknowledge that they have read and understand the Student / Parent/ Guardian Handbook for GHSA Sanctioned Interscholastic Activities 2004-2008 when they sign this form. Prior to participation in any conditioning, tryout, practice session, or play in any interscholastic athletic activity, the student-athlete **MUST SUBMIT this form to the coach of the activity. Failure to submit this form will delay the eligibility of the student athlete to join the team. *Warning!* Although participation in supervised interscholastic athletic and activities may be one of the least hazardous in which students will engage in and 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, including permanent paralysis from the neck down to death. Although serious injuries are not common in supervised athletic programs, it is possible only to minimize and not to eliminate the risk. Participants can and have the responsibility to help reduce the risk of injury. Participants must obey all safety rules, report all physical problems to their coaches and the school's athletic trainer, 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 the permission form.**

Date: _____ Sport / Activity: _____

Student Name: _____ Male ____ or Female ____
(Last Name) (First Name) (MI)

Address: _____
(# and Street Name) (City) (State) (Zip Code)

Home Tel. #: _____ Emergency Tel. # _____ Cellular Tel. #: _____

Name(s) of parent(s) /guardian(s) you live with: _____

The student is domiciled at the above address located in the _____ High School District.
(Name of School)

Date of Birth: _____ Age: _____ years. Date entered 9th grade: _____
(Month) (Day) (Year)

Your grade level for this school year: 9 10 11 12 Your expected year of Graduation: _____

This application to represent my school in interscholastic activities is entirely voluntary on my part and is made with the understanding that I have studied and understood the Eligibility Standards that I must meet to represent my school and that I have not violated any of these standards. I understand that meeting the citizenship standards set by the school or being ejected from an interscholastic contest because of an unsportsmanlike act, could result in my not being allowed to participate in the next contest or suspension from the team either temporarily or permanently. I understand that if I transfer to another school my eligibility may be affected under the Georgia High School Association's eligibility standards.

Student Signature: _____
(Signature) (School) (Date)

I (We) hereby give our consent for _____ to represent his/her school in interscholastic activities. We have received a Student/Parent Handbook for GHSA Sanctioned Interscholastic Activities. I (We) understand that we are responsible for reading the contents of this publication and that questions related to this publication can be addressed to the Fulton County Athletic Director at 404-763-6892. If I (we), the parent(s)/guardian(s), cannot be reached in the event of a medical emergency, I (we) do give consent for the school to obtain emergency transportation to the physician or hospital of its choice, and such medical care as is reasonably necessary for the welfare of the student if he/she is injured in the course of participation in interscholastic activities.

(1) I (We) give consent to participate the approved sports and activities except those that are CROSSED OUT below:

- | | | | | | |
|-----------------|------------|--------------|---------------|------------------|------------|
| Baseball | Basketball | Cheerleading | Cross Country | Debate/Forensics | Football |
| Golf | Gymnastics | Lacrosse | Literary | One-Act Play | Riflery |
| Soccer | Softball | Swimming | Tennis | Track and Field | Volleyball |
| Weight Training | | Wrestling | | | |

Continue to other side

- (2) I (We) give my consent to accompany any school team of which the student is a member on any of its local or out of town trips.
- (3) I (we) 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.
- (4) Students found illegally enrolled out of their school attendance zone could be ruled ineligible for GHSA competition for one (1) calendar year.
- (5) Parent(s) / guardian(s) should contact the Head Coach for information regarding injuries to their son / daughter.
- (6) That this acknowledgement of risk and consent to allow to participate shall remain in effect until revoked in writing.

All parents and guardians must sign and date this form

Signature of Parent / Guardian: _____ Date: _____

Signature of Parent / Guardian: _____ Date: _____

Signature of Student-Athlete: _____ Date: _____

Important: All student athletes must have medical / health insurance in order to participate in the Fulton County Schools GHSA Sanctioned Interscholastic Athletics and Activities Programs. Students must be enrolled in the medical / health insurance coverage that has been approved by the Fulton County School System or enrolled in substitute medical / health insurance through a bona fide insurance provider. Parent(s)/Guardian(s) must verify substitute insurance coverage.

VERIFICATION OF SUBSTITUTE INSURANCE COVERAGE

I (We) have waived the medical / health insurance coverage that has been approved by the Fulton County School System and offered to my child, _____ . Date of Birth: _____
 (Name of Child)

The medical/ health insurance that I am using for my child for the current school year at is provided by _____ and the insurance policy number is _____.
 (Name of Insurance Company) (Insurance Policy Number)

This insurance policy is in effect from: _____ to _____.
 (Date) (Date)

The above medical / health insurance coverage provides for the following interscholastic activities:

1. _____ 2. _____ 3. _____ 4. _____

I / We certify that the above information is accurate. I/We will submit notification to the school if there are any changes in the above policy.

ALL PARENTS/GUARDIANS/STUDENTS MUST SIGN BELOW AND DATE

Signature of Parent / Guardian: _____ Date: _____

Signature of Parent / Guardian: _____ Date: _____



Consent to Treatment and Release of Medical Information

Name: _____

Date: _____ Sport(s): _____ DOB: _____

I give authorization to the Gwinnett Hospital System (GHS) athletic training staff and student athletic trainers working with the GHS athletic training staff, to evaluate and treat any injuries or illnesses that may occur during his/her athletic participation at JOHNS CREEK HIGH SCHOOL.

This includes immediate first aid to my child, treatment, physical exam, and diagnostic procedures. No guarantees have been made that the evaluation, treatment, or rehabilitation services that my child receives will cure or fully return him/her to athletic participation.

I authorize necessary medical treatment and admission to any medical facility designated by the GHS athletic training staff or team physician.

I understand that I have the right to make decisions concerning my child's health care, including the right to refuse medical treatment and surgical procedures. However, I also understand that the final decision as to whether my child may participate in athletic activities at JOHNS CREEK HIGH SCHOOL rests solely with the GHS athletic training staff and team physician.

Parent/Guardian Signature _____ Date _____

To Athletic Trainers, Physicians, Hospitals, Clinics, and all Other Agencies:

If needed, You are hereby authorized and requested to give the GHS athletic training department a complete copy of all your records pertaining to my child's medical treatment including, but is not limited to, all physicals, athletic trainer's records, and any diagnosis, treatment, history and prognosis of any and all injuries.

Parent/Guardian Signature _____ Date _____

These authorizations are effective until such time that the signee submits a written and dated revocation of this document.

Gwinnett Medical Center

1000 Medical Center Boulevard | Lawrenceville, GA 30045 | 678-312-4321 | gwinnettmedicalcenter.org



CONSENT FOR COGNITIVE TESTING and RELEASE OF INFORMATION

I give my permission for (name of child) _____

(Child's date of birth) _____

to have a baseline and post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered at JOHNS CREEK HIGH SCHOOL. I understand that my child may need to be tested more than once, depending upon the results of the test, as compared to my child's baseline test, which is on file at the school. I understand there is no charge for the testing.

JOHNS CREEK HIGH SCHOOL'S certified athletic trainer may release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to my child's primary care physician, team physician, neurologist, or other treating physician as necessary for proper care.

I understand that general information about the test data may be provided to my child's guidance counselor and teachers, for the purposes of providing temporary academic modifications, if necessary.

Name of parent or guardian: _____

Signature of parent or guardian: _____

Date: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Name of doctor: _____

Name of practice or group: _____

Phone number: _____

Student's home address:

Parent or guardian phone numbers (please indicate preferred contact number & time if necessary):

_____ (H) _____ (W)

_____ (cell)

Gwinnett Medical Center



Medication Authorization

Name: _____

Date: _____ Sport(s): _____ DOB: _____

This letter is for the authorization of medications to be given to JOHNS CREEK Student Athletes. Please check if the athlete is able to take these medications. If athlete cannot have these medications, please write an explanation at the bottom of the page.

_____ Advil (ibuprofen)

_____ Tylenol (acetaminophen)

_____ Aleve (naproxen sodium)

_____ Pepto-Bismol/TUMS (bismuth subsalicylate)

_____ Heat Guard (electrolytes)

_____ Benadryl (diphenhydramine HCL) – for allergic reactions

List any other medications that you may wish to be provided:

PARENT/GUARDIAN SIGNATURE:

These authorizations are effective until such time that the signee submits a written and dated revocation of this document.

Gwinnett Medical Center

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