



ATHLETIC PARTICIPATION, WAIVER, INSURANCE, AND CONSENT FORM

*Parent/Guardian(s) and Student signature required at bottom of form & initials required as indicated below

PLEASE PRINT

Student Name (Last) (First) (Middle) (Grade Level 2017-18)

Address (Street) (City) (Zip)

(Parent Cell Phone #) (Parent Alternate Phone #) (Year Entered 9th Grade) (Date of Birth)

PARENT/GUARDIAN CONSENT FOR ATHLETIC PARTICIPATION

*Parent/Guardian and Student must both initial in blanks before each bold section below

Parent/Guardian Student

ACKNOWLEDGEMENT OF RISK: I understand and acknowledge that participation in inter-scholastic sports teams/clubs and events is voluntary and by its very nature possesses an actual or potential risk of emotional and physical injury/illness, which may range in severity from minor to long term catastrophic injury, up to permanent paralysis or death. While it is not possible to eliminate this risk, Students have the responsibility to help reduce the chance of injury. Students must obey all safety rules, report all physical problems to their coaches or supervisors follow a proper conditioning program and inspect equipment daily. Parents/Guardians or Students who do not wish to accept this risk should not sign this form.

Parent/Guardian Student

INSURANCE COVERAGE: I am aware there is no District insurance coverage for medical treatment of personal injuries or property damage which may arise out of Student's participation in inter-scholastic athletics, sports clubs and events. I understand my Student must have insurance coverage in order to participate.

Please CHECK one of the following statements regarding insurance coverage for Student for the current school year:

Student is adequately and currently covered by accident insurance that will cover injuries sustained while participating in inter-scholastic athletics, sports teams/clubs and events.

Insurance Company: Company Phone Number: Name of Insured: Policy Number:

I wish to purchase the Benefit Plan provided by the Cobb County School System. (A copy of this Benefit Plan should be attached)

Parent/Guardian Student

PHYSICAL EVALUATION AND MEDICAL TREATMENT: Per Georgia High School Association (GHSA) a Pre-participation Physical Evaluation must be performed by a physician (MD/DO), nurse practitioner or physician assistant to medically screen each student who participates in District athletic programs. I understand that this medical evaluation is general in nature and only performed for purpose of determining fitness for athletics. 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 requires immediate medical or surgical attention, I 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 appropriate) unless I am present and request otherwise or until I later request otherwise.

Parent/Guardian Student

REVIEW OF ATHLETIC HANDBOOK (including Board Policy IDF-R Athletic Code of Conduct): I acknowledge that I have reviewed and consent to the guidelines of the Student/Parent Athletic Handbook, which can be found on the Athletics page of the Cobb County School District website (cobbk12.org), the local high school website, or by request of a hardcopy to the local high school. I understand that both Student and Parent/Guardian are subject to the rules outlined in this handbook and that violations may result in school discipline and consequences up to Student's loss of the privilege of athletic participation and/or loss of Parent(s)/Guardian(s)' privilege of attending athletic events. I have read and understand the consequences of certain behavior(s) as outlined in the Code of Conduct.

Parent/Guardian Student

TRANSPORTATION AND TRAVEL: I acknowledge my understanding of the travel-related guidelines as outlined within the Student/Parent Athletic Handbook, including the responsibility of parent/guardian to arrange transportation when not District-provided. I consent for my Student to participate in school-sponsored athletic trips.

Parent/Guardian

Student

WAIVER: I 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 represent and warrant that I 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 understand, acknowledge, and agree that the Cobb County School District (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 hereby release, discharge, indemnify, and agree to hold harmless the CCSD District, 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 teams/clubs and events. For purpose of this Release, liability means all claims, demands, losses, causes of action, suits, or judgments 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 of any loss of or damage to property that occurs to Student or his or her property during 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, you acknowledge that you 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:

By signing below, Parent/Guardian and Student hereby agree to/give consent for participation in inter-scholastic athletics, sports teams/clubs and events for Cobb County School District of the below -indicated Student. You acknowledge that you have carefully reviewed and agree to all terms of athletic participation, including the voluntary waiver, verify that all information contained herein is accurate, and understand that any false information may result in Student’s ineligibility for athletic participation.

_____	_____	_____
Signature(s) of Parent(s)/Guardian(s)	Printed Name of Parent(s)/Guardian(s)	Date
_____	_____	_____
Signature of Student	Printed Name of Student	Date

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	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
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: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
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: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
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)?			40. Have you ever become ill while exercising in the heat?		
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?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, - therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
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)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			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 _____
parent/guardian _____

Signature of _____
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 _____
parent/guardian _____

Signature of _____
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/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 2019-2020 school year. This form will be stored with the athletic physical form and other accompanying forms required by Cobb County School District.

I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.

SIGNED: _____
(Student)

(Parent or Guardian)

DATE: _____