DEKALB COUNTY ATHLETIC PARTICIPATION CONSENT FORM

(Physicals must be on or after April 1, for the next school year) Three parental signatures required. All information must be provided.

PRINT NAME:_____**Male** _____ **Female** _____

(Last) (First) (Middle)

Address: _____

(Street) (City) (Zip)

Student lives with: _____ **Relationship:** _____

(indicate parents, mother only, father only, aunt, brother etc.)

Telephone: Home _____ **Work**_____ **Cell**_____

This information is for the school year 2____ - 2_____. Your grade level will be _____ (7, 8, 9, 10, 11, 12)

PARENTAL CONSENT FOR ATHLETIC PARTICIPATION

By its nature, participation in inter-scholastic athletics and intra-scholastic sports clubs includes a risk of injury which may range in severity from minor to long term catastrophic, including permanent paralysis or death. Although serious injuries are not common in supervised athletic programs or athletic clubs, it is possible only to minimize, not eliminate this risk.

Participants have the responsibility to help reduce the chance of injury. Participants must obey all safety rules, report all physical problems to their coaches or club supervisors follow a proper conditioning program and inspect their equipment daily.

I (We) hereby give consent for _____ to:

(Print full name)

1) Compete in athletics in the Dekalb County School District in the following Georgia High School Association approved Sport(s) **(Please circle each sport you approve)**

Baseball	Basketball	Golf	Volleyball	Swimming & Diving
Football	Softball	Wrestling	Cross Country	Cheerleading
Tennis	Rifle Team	Soccer	Track & Field	

2) To accompany any school team or sports club of which the student is a member on any of its local or out of town trips excluding over-night trips. I understand that transportation may or may not be provided by the DeKalb County School District. (In the event transportation is not provided by the School District, transportation will be the student's responsibility.)

3) I release and waive, and further agree to indemnify, hold harmless or reimburse the DeKalb County School District, the Board of Education, its successors and assigns, its members, agents, employees and representatives thereof, as well as trip supervisors, from and against any claim which I, any other parent or guardian, any sibling, the student , or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, from any losses, damages or injuries arising out of, during , or in connection with the student's participation in the activity, any trip associated with the activity, or the rendering of emergency medical procedures or treatment if any.

4) I have insurance for coverage of my son/ daughter in the form indicated below. (Please **initial** by the type of insurance coverage you have. (You must provide a copy of the insurance card or policy benefits as indicated.)

_____ My son/daughter is adequately and currently covered by accident insurance that will cover injuries sustained while participating in inter-scholastic Athletics (including, but not limited to, Varsity and Junior Varsity Football) and inter-scholastic clubs and activities. **(Attach copy of card)**

Insurance Company Name: _____

Name of Insured: _____

Policy number: _____

_____I have purchased the Benefit Plan provided by the DeKalb County School System. **(attach a signed copy of benefit plan)**

5) I 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.**

(Students found illegally enrolled out of their school attendance zone could be ruled ineligible for GHSA competition for one full year.

By signing this permission form, you acknowledge that you have read and understand the risks of participation and agree to the above terms. This acknowledgement of risk and consent to allow participation shall remain in effect until revoked in writing. (Parents or students who do not wish to accept any of these terms or risks should not sign and participation will be denied.)

_____ **DATE**_____

SIGNATURE(S) PARENT(S) OR GUARDIAN(S

_____ **DATE**_____

SIGNATURE OF STUDENT-ATHLETE

PREPARTICIPATION PHYSICAL EAVLUATION **HISTORY FORM**

NAME_____SEX _____AGE_____DATE OF BIRTH___/____/___

GRADE_____SPORT(S)_____

ADDRESS_____PHONE_____

PERSONAL PHYSICIAN_____DATE OF EXAM_____

I understand that this will serve as the basis for determining that my child may compete in Athletics, sports clubs and activities in DeKalb County Schools. I understand that this evaluation is only to determine fitness for athletics and is not to take the place of regular medical examinations

Explain "YES" answers below. Circle any questions you do not know the answers to.

	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?	☐	☐
2. Do you have an ongoing medical condition (like diabetes or asthma)?	☐	☐
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5. Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6. Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7. Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8. Does your heart race or skip beats during exercise?	☐	☐
9. Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection		
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	☐	☐
11. Has anyone in your family died for no apparent reason?	☐	☐
12. Does anyone in your family have a heart problem?	☐	☐
13. Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
14. Does anyone in your family have Marfan syndrome?	☐	☐
15. Have you ever spent the night in a hospital?	☐	☐
16. Have you ever had surgery?	☐	☐
17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:	☐	☐
18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

	Yes	No
20. Have you ever had a stress fracture?	☐	☐
21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22. Do you regularly use a brace or assistive device?	☐	☐
23. Has a doctor ever told you that you have asthma or allergies?	☐	☐
24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
25. Is there anyone in your family who has asthma?	☐	☐
26. Have you ever used an inhaler or taken asthma medicine?	☐	☐
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28. Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29. Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30. Have you had a herpes skin infection?	☐	☐
31. Have you ever had a head injury or concussion?	☐	☐
32. Have you been hit in the head and been confused or lost your memory?	☐	☐
33. Have you ever had a seizure?	☐	☐
34. Do you have headaches with exercise?	☐	☐
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36. Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37. When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39. Have you had any problems with your eyes or vision?	☐	☐
40. Do you wear glasses or contact lenses?	☐	☐
41. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42. Are you happy with your weight?	☐	☐
43. Are you trying to gain or lose weight?	☐	☐
44. Has anyone recommended you change your weight or eating habits?	☐	☐
45. Do you limit or carefully control what you eat?	☐	☐
46. Do you have any concerns that you would like to discuss with a doctor?	☐	☐
FEMALES ONLY		
47. Have you ever had a menstrual period?	☐	☐

48. How old were you when you had your first menstrual period? _____

49. 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

PHYSICAL EXAMINATION FORM

Name _____ Date of Birth _____

Height _____ Weight _____ % Body Fat (optional) _____ Pulse _____ BP ____ / ____ (____ / ____, ____/____)

Vision R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

*Multiple-examiner set-up only
+Having a third party present is recommended for the genitourinary examination

Notes: _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Preparticipation Physical Evaluation

CLEARANCE FORM

Name_____Sex_____Age_____Date of birth_____

☐ Cleared without restriction
☐ Cleared, with recommendations for further evaluation or treatment for:_____
_____
_____
_____

☐ Not Cleared for ☐ All sports ☐ Certain sports: _____ Reason:_____

Recommendations:_____
_____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____Date _____

Address _____Phone _____

Signature of physician _____, MD or D

In case of an emergency or accident on the school grounds or during any school activity involving my child_____ which in the opinion of the school authorities present requires immediate medical or surgical attention, I hereby grant permission to said school authorities to obtain the services of a physician or to transport said child to the hospital if it is deemed necessary by school authorities. I hereby grant permission, also, to said physicians to treat said condition unless I am present and request otherwise or until I later request otherwise.

_____ **DATE**_____
SIGNATURE(S) OF PARENT(S)/ GUARDIAN(S)

Relation to Student (Please check one) **Mother**_____**Father**_____**Both Parents**_____

Court Ordered Guardian_____ **Other**_____**Explain**_____

EMERGENCY MEDICAL INFORMATION

STUDENT NAME_____

PARENT(S) NAME_____

Parents Adress_____

Work Phone #_____**Home Phone#** _____**Cell#**_____

Emergency #1_____**Emergency #2**_____
Hospital Preference_____
Primary Physician's Name _____**Number**_____
Insurance Company Name _____**Card #**_____

Coach: make a copy of this page and keep in your Medical Kit.