



EMERGENCY CONTACT & INSURANCE INFORMATION

Student's Name (Legal) Social Security # LAST FIRST MI D.O.B 2017-18 Grade Level:

Address: STREET CITY GA ZIP

Student's Home Phone #: Student's Cell Phone #:

Child Lives With: Father Mother Both Other:

Father/Guardian's Name: Home Phone #:

Father/Guardian's Employer:

Father/Guardian's Cell Phone # Work Phone # ext

Mother/Guardian's Name: Home Phone#:

Mother's Employer:

Mother/Guardian's Cell Phone # Work Phone # ext

Parent/Guardian contact e-mail address:

Emergency Contact & Relationship (must be 21 or older):

Contact Home Phone # Contact Cell Phone #

Primary Physician: Office Phone # ext

INSURANCE INFORMATION

Primary Insurance Co: Name of Policy Holder:

Policy #: Group #:

Insurance Co. Phone # ext

\*\*PLEASE BE AWARE OF THE FOLLOWING WHEN CARING FOR MY CHILD\*\*

Medical Conditions:

Allergies:

Medications & Condition:

PERMISSION FOR AUTHORIZATION TO TREAT IN PARENT ABSENCE

\*I give permission for representatives of Savannah Christian Preparatory School to authorize medical treatment for my child in my absence. This may include, but is not limited to, activation of emergency services, emergency room procedures, and injury/illness evaluation and treatment by certified athletic trainers at away competitions.

Print Parent Name: Parent Signature:

**\*PLEASE ATTACH COPY**

**(FRONT/BACK) OF**

**STUDENT'S**

**INSURANCE CARD\***



PERMISSION & MEDICAL RECORD RELEASE FORM

Student's Name: Last First M.I.

ASSUMPTION OF RISK AND PERMISSION TO TREAT

I am aware playing or practicing to play/participate in any sport or sport related activity could be a dangerous activity involving MANY RISKS OF INJURY. I understand that the dangers and risks of playing or practicing to play/participate in sports or sport related activity include, but are not limited to: death; serious neck and spinal injuries that may result in complete or partial paralysis; brain damage; serious injury to virtually all bones, joints, ligaments, muscles, tendons, other aspects of the musculoskeletal system and vital organs; and serious impairment to other aspects of the body, general health, and well-being. I understand the dangers and risks of playing or practicing to play/participate in any sport or sport related activity may result not only in serious injury, but in a serious impairment of my (the participant's) future abilities to earn a living; to engage in other business, social, and recreational activities; and generally enjoy life. Because of the dangers of playing or practicing to play/participate in any sport or sport related activity, I recognize the importance of following the coach's, official's and medical staff's instructions regarding playing techniques, training, and other team rules, etc., and agree to obey such instructions.

As the parent / legal guardian of the above named participant, I have read the above warnings and release, and understand its terms. I hereby agree to hold the Savannah Christian Preparatory School, its direct and contracted employees, agents, representatives, coaches and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever that may arise by or in connection with participation of my child in any activities related to Savannah Christian Preparatory School activities. The terms hereof will serve as a release for my heirs, estate, executor, administrator, assignees, and for all members of my family. Whenever injury and/or sickness occur to the participant listed above, and the participant is under the supervision of Savannah Christian Preparatory School, and the participant's parent / legal guardian is unavailable to give his/her permission for treatment, the participant and others whose signatures are attached below do hereby give permission to Memorial Health and Memorial Sports Medicine to authorize any emergency action necessary to ensure the safety of the child. The intention hereof being to grant authority to administer and perform all and singularly any examinations, pre-participation physical examinations, treatments, anesthetics, operations, and diagnostic procedures which may now, or during the course of this participant's care, be deemed advisable or necessary. This does not hold Memorial Health and/or the Savannah Christian Preparatory School financially responsible for any medical care given. An insurance policy may be available through the school for an additional cost.

I specifically acknowledge that Football and Wrestling are collision sports that involve an even greater risk of injury than contact sports: Basketball, Baseball, Cheerleading, Lacrosse, Soccer, Softball, and Volleyball which involve greater risk of injury than non-contact sports: Bowling, Cross Country, Equestrian, Golf, Rowing, Swimming, Track & Field and Tennis.

Student's Signature Date Parent /Guardian Signature Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

General Disclosure:

I hereby authorize Memorial Health and/or Memorial Sports Medicine Medical Personnel to release information from my medical records for the purpose of payment, treatment or operations to their Business Associate Partner (which includes; the Attending School's Coaching Staff and Administrators) and any Hospital in case of an Emergency Situation. This authorization shall be valid for the duration of the 2016-2017 school year. It is subject to revocation by the patient, or the parent / guardian at any time except to the extent that action has been taken in reliance thereon. I am aware that once Memorial Health and/or Memorial Sports Medicine discloses this information per my instructions, the information is subject to re-disclosure and may no longer be protected by the HIPAA (Health Insurance Portability and Accountability Act) of 1996. I understand that a photocopy of this authorization shall be as valid as the original. I know that I, or my authorized representative may receive a copy of this authorization upon request.

Student's Signature Date Parent/Guardian Signature Date



## **GHSA: HEAT & HUMIDITY POLICY**

### **Heat and Humidity Awareness:**

GHSA has a statewide practice policy for extremely high heat and humidity that list guidelines for monitoring the heat during sports that occur in the warmer months. This includes practices, games, and voluntary conditioning.

#### **GUIDELINES FOR HYDRATION AND REST BREAKS:**

- Rest time should involve both unlimited hydration intake (water or electrolyte drinks) and rest without any activity.
- For football, helmets should be removed during rest time.
- The site of rest should be a “cooling zone” and not in direct sunlight.
- When the WBGT reading is over 86:
  - Ice towels and spay bottles filled with ice water should be available at the “cooling zone” to aid the cooling process
  - Cold immersion tubs must be available for practices for the benefit of any player showing early signs of heat illness.

Please refer to BY-LAW 2.67-GHSA Practice Policy for Heat and Humidity for more details:  
<http://www.ghsa.net/sites/default/files/documents/sports-medicine/HeatPolicy2013.pdf>

It is recommended that all guidelines be followed in such a way that the best interests of our students be made our number one priority. It is also recommended that coaches constantly teach our students about proper hydration throughout each day. It is important that student-athletes be allowed to carry water with them during the day and hydrate themselves, on days of practices and games, while the weather has the possibility of reaching critical levels in relation to the heat and humidity.

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

\_\_\_\_\_

*Student Athlete Signature*

\_\_\_\_\_

*Date*

\_\_\_\_\_

*Parent/Guardian Signature*

\_\_\_\_\_

*Date*



**Memorial Sports Medicine**

**CONCUSSION AWARENESS INFORMATION AND GUIDELINES**

The purpose for this document is to provide crucial information for student-athletes and parents/legal guardians. This form must be signed by both the athlete and parent/legal guardian prior to tryouts, workouts or other forms of participation.

**Concussion Awareness Information:**

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 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.

**COMMON SIGNS OF A 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.)

Please refer to BY-LAW 2.68-GHSA Concussion policy for more details:

[http://www.ghsa.net/sites/default/files/documents/sports-medicine/2013GHSAConcussion\\_Form.pdf](http://www.ghsa.net/sites/default/files/documents/sports-medicine/2013GHSAConcussion_Form.pdf)

**Student-Athlete Concussion/Head Injury Guidelines:**

I affirm that:

- It is my responsibility as a student athlete or as the parent/legal guardian of a student athlete to report all injuries and illnesses to my Athletic Trainer or Memorial Sports Medicine representative.
- I have fully disclosed, in writing, all prior head injury related events and medical conditions and will disclose any future conditions to my Athletic Trainer or Memorial Sports Medicine representative.
- I understand the importance of and will immediately report any and all signs and symptoms of a head injury, including concussion, to the Memorial Sports Medicine representative or my Head Coach.
- I understand there is the possibility that participation in any sport may result in a head injury and/or concussion.
- I will be provided with the Heads Up-Concussion Fact Sheet / NCAA Concussion Fact sheet for student-athletes.
- If there are questions or I wish to discuss any areas and issues that are not clear to me concerning head injuries, I have the contact information of a Memorial Sports Medicine Athletic Trainer.
- I acknowledge that no piece of equipment can prevent injury/illness/concussion. Specifically, helmets or soccer headbands may help to prevent catastrophic head injury but do not significantly reduce the risk of a head injury, including concussion. I understand that it is my responsibility to wear (or to ensure the student-athlete wears) any equipment issued to me (or the student-athlete) in the appropriate manner.
- I agree to read and abide by all warning labels on any equipment before use.
- I have read and reviewed the following statement released by the National Operating Committee on Standards for Athletic Equipment (NOCSAE)
  - **Helmet Warning Statement** (For those student-athletes who will play football at any level):
    - **“Keep your head up. Do not use this helmet to butt, ram, or spear an opposing player with any part of this helmet or faceguard. This is in violation of football rules and such use can result in severe head or neck injuries, paralysis, or death to you and possible injury to your opponent. No helmet can prevent all head or neck injuries a player might receive while participating in football.”**

**BY SIGNING I AFFIRM THAT I HAVE READ THIS FORM AND I UNDERSTAND ALL THE FACTS PRESENTED IN IT.**

\_\_\_\_\_  
**Student Athlete Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

# Savannah Christian Preparatory School Medication Consent Form

Permission is hereby granted to the Head Athletic Trainer to dispense the following over-the-counter medications to my child: (please check chosen medications)

- |  |   |
|--|---|
| <input type="checkbox"/> Acetaminophen (Tylenol)   | <input type="checkbox"/> Nasal Relief Spray                   |
| <input type="checkbox"/> Ibuprofen (Advil)         | <input type="checkbox"/> Antacid Tablets                      |
| <input type="checkbox"/> Naproxen Sodium (Aleve)   | <input type="checkbox"/> Pepto-Bismol                         |
| <input type="checkbox"/> Midol                     | <input type="checkbox"/> Anti-histamine (Diphenhydramine HCL) |
| <input type="checkbox"/> Migraine Relief           | <input type="checkbox"/> Sore Throat Spray                    |
| <input type="checkbox"/> Electrolytes (Medi-Lyte)  | <input type="checkbox"/> Cough Drops                          |
| <input type="checkbox"/> Electrolytes (Heat Guard) |   |

**OR**

I **DO NOT** wish any medications to be given to my child

Current Medical Concerns: (allergies, athma, etc) \_\_\_\_\_

Current Medications your child is taking: \_\_\_\_\_

- If your child is currently taking any medications prescribed by a physician, please go ahead and obtain a written note from the MD stating that your child is prescribed the medication and is clear to play sports on such medication. Please attach this to this form. If you do not have this prior to the physical, your child may be disqualified until the information can be submitted.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

Phone: (Home) \_\_\_\_\_ (other) \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone \_\_\_\_\_

Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_



**SAVANNAH CHRISTIAN PREPARATORY SCHOOL  
ATHLETIC DEPARTMENT**

1599 Chatham Pkwy  
P.O. Box 2848  
Savannah, GA 31402-2848

(912) 234-1653  
(912) 234-0491 Fax



**PARENTAL PERMISSION AND RELEASE FORM**

Student's Name: \_\_\_\_\_

Homeroom Grade & Section: \_\_\_\_\_

We hereby give permission for our child to participate in the athletic/extracurricular activity programs of Savannah Christian Preparatory School.

We understand that injuries may occur while participating in these programs and we will not hold Savannah Christian nor its coaches, faculty or staff liable for any expenses thereof.

We also understand that SCPS provides student accident insurance at no cost to us and that this insurance is a SUPPLEMENTAL PLAN and is subject to a DEDUCTIBLE, LIMITATIONS AND EXCLUSIONS which may result in balances owed by the parents. We further understand that this supplemental policy is designed to complement our family coverage (private or group policy), and that a copy of its provision will be available from the school office.

Parent's Signature: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Student's Signature: \_\_\_\_\_

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

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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

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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

2017-2018

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* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) <sup>b</sup>			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic <sup>c</sup>			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.  
<sup>c</sup>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 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**

**2017-2018**

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 \_\_\_\_\_  
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