Athletic Participation/Permission Form

I, the undersigned, am the parent/legal guardian of _____.
(Athlete Name -please print)

I, hereby give consent for a Certified Athletic Trainer, an employee of Chatham Orthopaedic Associates, P.A. ("Facility Personnel") who is contracted by **Savannah Christian Preparatory School** (School), to provide sports medicine and/or athletic training services for the above referenced athlete. Sports medicine athletic training services include, but are not limited to: administering first aid for athletic injuries; providing initial treatment and management of acute injuries; and assessing athletic injuries at the request of the athlete, the athlete's coach, or the athlete's parent/guardian. The Facility Personnel will perform only those services that are within their training and scope of professional practice. I understand that as a result of the medical evaluation provided by the Facility Personnel, the athlete may be transported to a hospital emergency department for further treatment. I understand that a written report of any athletic injury assessment will be confidentially maintained in School's files.

If the athlete is in need of further treatment by a physician, or of rehabilitation services for the injury, he or she may see the physician or provider of his/her choice. Injured athletes that have seen a physician must submit written clearance from that physician to School and/or Facility Personnel prior to being permitted to resume athletic activity. This Authorization shall remain in effect for one sports season beginning with the date set forth below.

Parent/Guardian Name (Print) _____

Parent/Guardian (Signature)_____ Date_____

Athlete's Emergency Contact_____

Relationship to Student Athlete _____ Cell/Work Phone_____

Home Address _____Home Phone_____

Student Athletes Name _____Date of Birth _____

Allergies:_____

Current Medications (i.e. asthma inhalers, epi-pen, etc…):_____

Physical impairments_____

Other pertinent medical history (surgeries, diabetes, seizures, heart condition, etc…) _____

_____

_____

Physician Name _____ Physician Phone _____

CHATHAM ORTHOPAEDIC ASSOCIATES

Authorization for Release of Protected Health Information

This Authorization for Release of Protected Health Information Form ("Authorization") allows for the release of protected health information to Savannah Christian Preparatory School ("School") by employees of Chatham Orthopaedic Associates, P.A. ("Facility Personnel"), who render services to the student athlete listed below ('Student Athlete"). The purpose of this Authorization is to allow Facility Personnel who provide services to School to communicate with School regarding the Student Athlete's protected health information and participation in School athletic events. Facility Personnel will not condition treatment on whether this authorization is signed.

I hereby authorize Facility Personnel providing services to School to release to each other and to School information, including protected health information, related to the Student Athlete's medical or physical condition, illness or injury that may have a bearing upon participation in School's athletic events. The Student Athlete's medical information should be used by the School and Facility Personnel for the purpose of determining the advisability of the Student Athlete's participation in School athletic events and/or any limitations on the Athlete's participation. I understand that the Student Athlete's health information is protected by the federal regulations under the Health Information Portability and Accountability Act of 1996 (HIPM). This Authorization is expressly made on the following conditions:

This Authorization will automatically expire upon the Student Athlete's termination of participation or eligibility in School athletic events, except to the extent relied upon for disclosures made prior to the automatic expiration.

This Authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to School. As soon as practicable, School shall inform all Facility Personnel of the Student Athlete's revocation. Any such revocation shall not affect disclosures made by Facility Personnel prior to the receipt of the revocation from the School made in reliance on this Authorization.

This Authorization is not intended to alter the Student Athlete's ability to receive medical care from any health care provider regardless of whether this Authorization is agreed to or refused.

The Student Athlete and Parent Guardian shall receive a complete copy of the signed Authorization, and a copy of this Authorization and any revocation of it will be kept by School.

The undersigned understands and agrees that medical or health information disclosure by Facility Personnel pursuant to this authorization may be subsequently disclosed by the recipient and may no longer be protected by applicable law.

If I have questions about disclosure of my health information, I may contact Alaina Cooper at (912) 355-6615.

_____ _____

Student Athlete (Signature Parent/Guardian Signature

_____ _____

Student Athlete (Printed Name) Parent/Guardian (Printed Name)

& Relationship to Athlete

_____ 4818-8830-6638, v.2

Date

CheckGeorgia High School Association

HEAT & HUMIDITY POLICY

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.

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

Student-Athlete Concussion/Head Injury Guidelines:

- 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 may be provided with the Heads Up-Concussion Fact Sheet / NCAA Concussion Fact sheet for student-athletes upon request
- 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
Athletic Department

Student's Name: _____2020-2021 Grade: _____

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

_____ Acetaminophen (Tylenol)
_____ Ibuprofen (Advil)
_____ Naproxen Sodium (Aleve)
_____ Midol
_____ Migraine Relief
_____ Electrolytes (Medi-Lyte)
_____ Electrolytes (Heat Guard)
_____ Nasal Relief Spray
_____ Antacid Tablets
_____ Pepto-Bismol
_____ Anti-histamine (Dipenhydramine HCL)
_____ Sore Throat Spray
_____ Cough Drops

OR

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

Current Medical Concerns: (allergies, asthma, 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.

PARENTAL PERMISSION AND RELEASE FORM

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: _____

Georgia High School Association
Student/Parent Sudden Cardiac Arrest Awareness Form

SCHOOL: _____

1: Learn the Early Warning Signs

If you or your child has had one or more of these signs, see your primary care physician:

- Fainting suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones
- Unusual chest pain or shortness of breath during exercise
- Family members who had sudden, unexplained and unexpected death before age 50
- Family members who have been diagnosed with a condition that can cause sudden cardiac death, such as hypertrophic cardiomyopathy (HCM) or Long QT syndrome
- A seizure suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones

2: Learn to Recognize Sudden Cardiac Arrest

If you see someone collapse, assume he has experienced sudden cardiac arrest and respond quickly. This victim will be unresponsive, gasping or not breathing normally, and may have some jerking (Seizure like activity). Send for help and start CPR. You cannot hurt him.

3: Learn Hands-Only CPR

Effective CPR saves lives by circulating blood to the brain and other vital organs until rescue teams arrive. It is one of the most important life skills you can learn – and it's easier than ever.

- Call 911 (or ask bystanders to call 911 and get an AED)
- Push hard and fast in the center of the chest. Kneel at the victim's side, place your hands on the lower half of the breastbone, one on top of the other, elbows straight and locked. Push down 2 inches, then up 2 inches, at a rate of 100 times/minute, to the beat of the song "Stayin' Alive."
- If an Automated External Defibrillator (AED) is available, open it and follow the voice prompts. It will lead you step-by-step through the process, and will never shock a victim that does not need a shock.

By signing this sudden cardiac arrest form, I give _____ High School permission to transfer this sudden cardiac arrest form to the other sports that my child may play. I am aware of the dangers of sudden cardiac arrest and this signed sudden cardiac arrest form will represent myself and my child during the 2020-2021 school year. This form will be stored with the athletic physical form and other accompanying forms required by the _____ School System.

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

_____	_____	_____
Student Name (Printed)	***Student Name (Signed)***	***Date***
_____	_____	_____
Parent Name (Printed)	***Parent Name (Signed)***	***Date***

(Revised: 2/20)

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 ≥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 *Staphylococcus aureus* (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.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

1. 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?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	☐	
Eyes, ears, nose, and throat • Pupils equal • Hearing	☐	
Lymph nodes	☐	
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	☐	
Lungs	☐	
Abdomen	☐	
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis	☐	
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 • Double-leg squat test, single-leg squat test, and box drop or step drop test	☐	

[a] 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: _____

_____

_____