


**MUST BE FILLED OUT IN
BLACK  INK ONLY!**

Sports Physical Basic Information

Student's Name: _____

Date of Birth: _____

Gender: () Male () Female () _____

Race: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize Community Health Care Systems, Inc., to perform a sports physical on this student.

Parent or Legal Guardian's Name: _____

* Signature of Parent or Legal Guardian: _____ Date: _____

Relationship if other than Parent: _____

Parent or Legal Guardian's Phone Number: _____

TO Get physical -

- **MUST BE FILLED OUT IN BLACK INK**
- **ALL PAGES MUST BE SIGNED**
- **FILL OUT ALL SECTIONS OF THIS PACKET**

■ 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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		Yes	No
<i>(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)</i>			
1. Do you have any concerns that you would like to discuss with your provider?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
<i>(CONTINUED)</i>			
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	<input type="checkbox"/>	<input type="checkbox"/>	
MEDICAL QUESTIONS		Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	<input type="checkbox"/>	<input type="checkbox"/>	
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	<input type="checkbox"/>	<input type="checkbox"/>	
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?	<input type="checkbox"/>	<input type="checkbox"/>	
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
22. Have you ever become ill while exercising in the heat?	<input type="checkbox"/>	<input type="checkbox"/>	
23. Do you or does someone in your family have sickle cell trait or disease?	<input type="checkbox"/>	<input type="checkbox"/>	
24. Have you ever had or do you have any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>	

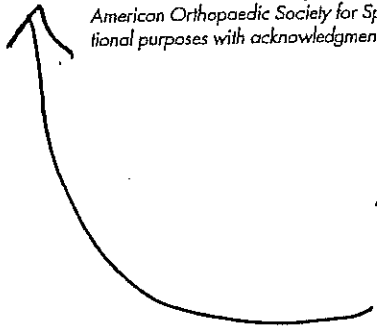
MEDICAL QUESTIONS (CONTINUED)		Yes	No
25. Do you worry about your weight?	<input type="checkbox"/>	<input type="checkbox"/>	
26. Are you trying to or has anyone recommended that you gain or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>	
27. Are you on a special diet or do you avoid certain types of foods or food groups?	<input type="checkbox"/>	<input type="checkbox"/>	
28. Have you ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
FEMALES ONLY		Yes	No
29. Have you ever had a menstrual period?	<input type="checkbox"/>	<input type="checkbox"/>	
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: _____

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PARENT MUST SIGN

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

EXAMINATION		
Height: _____	Weight: _____	
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, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	<input type="checkbox"/>	
Eyes, ears, nose, and throat • Pupils equal • Hearing	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart* • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder and arm	<input type="checkbox"/>	
Elbow and forearm	<input type="checkbox"/>	
Wrist, hand, and fingers	<input type="checkbox"/>	
Hip and thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg and ankle	<input type="checkbox"/>	
Foot and toes	<input type="checkbox"/>	
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test	<input type="checkbox"/>	

* 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: _____

Georgia High School Association
 Student/Parent Concussion Awareness Form

SCHOOL: JOHNSON COUNTY

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 or 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 injury to the brain, and sweat 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 GHSAA 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/fatigue
- Nausea or vomiting
- Blurred vision, sensitivity to light and sounds
- Foggiess 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 2.8B: GHSAA 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 (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.

By 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 graded return to play protocol shall be a part of the medical clearance.

JOHNSON COUNTY

By signing this concussion form, I give 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 2017-2018 school year. This form will be stored with the athletic physical form and other accompanying forms required by the JOHNSON COUNTY 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 _____

5-6-17
 [Redacted]

HEAT POLICY PLAYER HANDOUT

- (a) Schools must follow the statewide policy for conducting practices and voluntary conditioning workouts (including during the summer) in all sports during times of extremely high heat and/or humidity that will be signed by each head coach at the beginning of each season and distributed to all players and their parents or guardians. The policy shall follow modified guidelines of the American College of Sports Medicine in regard to:
 - (1) The scheduling of practices activities heat/humidity levels
 - (2) The ratio of workout time to time allowed for rest and hydration at various heat/humidity levels
 - (3) The heat/humidity levels that will result in practices being terminated
- (b) A scientifically-approved instrument that measures the Wet Bulb Globe Temperature must be utilized at each practice to ensure that the written policy is being followed properly. WBGT should be taken every hour, beginning 30 minutes before the beginning of practice.

WBGT ACTIVITY GUIDELINES AND REST BREAK GUIDELINES

Under 82.0 Normal Activities - Provide at least three separate rest breaks each hour with a duration of 9 minutes each during the workout.
 82.0 - 85.9 Use discretion for intense or prolonged exercise; watch athletes play/sports carefully. Provide at least three separate rest breaks each hour with a minimum duration of 4 minutes each.
 87.0 - 89.9 Maximum practice time is 2 hours. For Football: Players are restricted to helmets, pads, and short drying practices, and all protective equipment must be removed during conditioning activities. If the WBGT rises to this level during practice, players may continue to work out wearing football pants without engaging in shorts. For All Sports: Provide at least four separate rest breaks each hour with a minimum duration of 4 minutes each.
 90.0 - 92.0 Maximum practice time is 1 hour. For Football: no protective equipment may be worn during practice, and there may be no conditioning activities. For All Sports: There must be 20 minutes of rest breaks distributed throughout the hour of practice.
 Over 92.1 No outdoor workouts. Delay practice until a cooler WBGT level is reached.

Johnson County High School is committed to follow the GHSAA Heat Regulations
 STUDENT SIGNATURE _____
 5/12/2017

Reading Program Permission Form

Your student athlete may be invited to go to the JCES during the 2017-18 school year to read to the elementary students. This program would typically take place on a Friday and would last for about 1 hour. The intention is to encourage reading and literacy amongst my son/daughter to go to the elementary school. I am aware and agree to allow the students will read to JCES.

Student Athlete _____
 Parent Signature _____ Date _____



Sport _____
Year _____

REGISTRATION FORM

Student Name _____ Age _____ Date of Birth _____

Address _____ City _____ Phone _____

Parent(s)/ Guardian _____ Grade _____

Father's Business _____ Phone _____

Mother's Business _____ Phone _____

Family Doctor _____ Insurance _____

Check one: My child has insurance _____ My child does not have insurance _____

Fill out and sign below: Type of Family Insurance: _____

Insurance Policy #: _____

Parent(s)/Guardian's Signature _____ Date _____

INSURANCE WAIVER

By signing this waiver, I realize that I have insurance for my child or do not wish for my child to be covered by insurance. I agree not to hold the school or anyone acting on behalf responsible for any injury occurring to my son/daughter in the proper course of such athletic activities or travel.

Parent Signature _____ Date _____

Parent Initials *Parent Initials*

Parent Permission For Students Athlete Participation

Dear Parent(s) or Guardian(s):

The school's athletic program is an integral part of the curriculum, and school personnel have devoted great effort to assure that participating students are protected in every way possible. However, participation in athletics includes a risk of injury, which may range in severity from minor to long-term catastrophic, including paralysis and death.

Participants have the responsibility to hold reduce the chance of injury. Participants must obey all safety rules and regulations, participate in all physicals, report all problems to the coach, follow a proper conditioning program and inspect personal protective equipment daily. Proper execution of skill techniques must be followed for every sport.

This is the policy of the Johnson County Board of Education that all athletic participants purchase school insurance or sign an insurance waiver. The school's Athletic Program is not authorized to extend public funds or injuries; thus, it will be the responsibility of the parent or guardian to pay any cost of injury, which is not covered by insurance. (PLEASE INITIAL EACH OF THE FOLLOWING STATEMENTS TO SHOW THAT THE STATEMENT HAS BEEN READ, UNDERSTOOD, AND APPROVED.)

I consent to have my son/daughter represent his/her school in approved athletic activities except those activities excluded by the examining doctor.

I grant permission for my son/daughter to accompany any school team of which he/she is a member to out-of-town trips. The athlete will be transported to and from all events in school approved vehicles.

In the event of an emergency requiring medical attention, I understand every attempt will be made to contact me. In case I cannot be reached, I grant permission for any immediate treatment deemed necessary by the attending physician and transfer of my son/daughter to a qualified medical facility.

I acknowledge and accept the risks of physical injury involved in athletic participation, which may result in permanent paralysis, mental disability, and death.

I agree not to hold the school or anyone acting on behalf responsible for any injury occurring to my son/daughter in the proper course of such athletic activities or travel. I grant permission for any designated member of the school's coaching staff to perform minor first aid treatment.

Date: _____ Signature of Guardian _____

S I G N I N G



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

SCHOOL: Johnson County

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 Johnson County 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 2019-2020 school year. This form will be stored with the athletic physical form and other accompanying forms required by the JOHNSON COUNTY 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: 5/19)