

PARENTS CONSENT TO PARTICIPATE

Students who participate in the interscholastic program at Rabun County Middle and High School must meet and maintain the academic eligibility standards of the Georgia High School Athletic Association and the Rabun County School Board. Students must also pass a physical examination by a licensed physician before they can try out or participate. The administration and coaching staff expect these students to maintain high standards of sportsmanship and citizenship at all times.

STUDENT NAME: _____ Date of Birth: ____/____/____

ADDRESS: _____ CITY/ZIP _____

AGE: _____ GRADE _____ SEX _____

TRAVEL CONSENT & TREATMENT AUTHORIZATION

We hereby give our consent for THE STUDENT NAMED ABOVE to represent Rabun County High School in interscholastic athletics. We give our consent for him/her to accompany the team on trips under the supervision of coaches employed by the Rabun County Board of Education and will not hold the school responsible in case of accident injury.

If we cannot be reached, we give consent for school officials to obtain such medical care as is necessary for the welfare of our child.

CONTACT INFORMATION:

Home Number: _____ Work Phone: _____

Emergency Phone #(s): _____ Player's Cell #: _____

Students who participate in interscholastic athletics must verify that they have insurance that covers the participation. You should understand that injury is possible when students train for and compete in athletic contests. Rabun County High School can not assume responsibility for medical expenses that might result from participation in interscholastic athletics. Please give the information asked for below and sign this form. Your signature states that you understand the information given in this document and that you give consent for your child named above to represent his/her school in interscholastic competition.

Signature of Parents or Guardians _____

All Parents or Guardians must sign _____

CHECK ONE:

____ We do not have insurance that covers our child's participation and will need to purchase school insurance.

____ Our child is covered by the insurance policy listed below:

Insurance Co. _____ Policy # _____

Date: ____/____/____

EXHIBIT B - Athletic Participation/Permission Form

I, the undersigned, am the parent/legal guardian of _____,

a Student-Athlete at _____ (school) who plans to participate

in the following sports _____.

I hereby give consent for a Certified Athletic Trainer, an employee of Mountain Lakes Medical Group (Hospital), who is under a memorandum of understanding with the School District, to provide sports medicine and/or athletic training services for the above named Student-Athlete. Sports medicine athletic training 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 Student-Athlete, the Student-Athlete's coach, or the Student-Athlete's parent/guardian. The Certified Athletic Trainer will perform only those services that are within their training and scope of professional practice to prevent, care for, and rehabilitate athletic injuries of the Student-Athlete. I understand that as a result of the medical evaluation provided by the Certified Athletic Trainer, the Student-Athlete may be transported to a hospital emergency department for further treatment. I understand that a documented report of any athletic injury assessment will be confidentiality maintained in the files of the training room and/or school nurse.

I hereby release the Hospital, its employees, agents, technicians, and any physician performing services from any liability for actions, other than their own negligence, that are taken in good faith reliance on this consent, and I agree that they may rely on this consent until such time as I personally notify them that the consent has been revoked.

I understand that there is no charge to me for the above listed athletic training services. If the Student-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 provide of his/her choice. Injured Student-Athletes that have seen a physician must submit written clearance from that physician to the School District and/or Certified Athletic Trainer prior to being permitted to resume athletic activity. This authorization shall remain in effect for the duration of the current school year as indicated by the date set forth below.

Parent/Guardian Name (Print): _____

Parent/Guardian (Signature): _____

Student-Athlete Name (Print): _____

Student-Athlete (Signature): _____

Date: _____

EXHIBIT C - 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 Rabun County School District ("School District") by employees of Mountain Lakes Medical Group ("Hospital"), who render services to the Student-Athlete listed below ("Student-Athlete"). The purpose of this Authorization is to allow Hospital Personnel, who provide services to the School District, to communicate with the School District, the School District's coaching staff, and any other School District personnel involved in the operation, administration, or management of the School District's athletic programs, regarding the Student-Athlete's protected health information and participation in the School District's Athletic Events. For example, this Authorization allows Hospital Personnel to communicate during a game with School District coaches about the condition of the Student-Athlete's injury and/or whether there are medical concerns that prevent the Student-Athlete's return to the athletic event. The Student-Athlete's injuries/illnesses may or may not be a direct result of athletic participation. Hospital Personnel will not condition treatment on whether this authorization is signed; however, the School District may not permit a Student-Athlete to participate in School District Athletic Events if the Student-Athlete and his/her parent/guardian have not signed this Authorization.

I hereby authorize Hospital Personnel providing services to the School District to release to each other and to the School District oral and written information related to the Student-Athlete's medical or physical condition, illness or injury that may have a bearing upon participation in the School District's Athletic Events. This protected health information may concern the Student-Athlete's medical status, medical condition, injuries, prognosis, athletic participation status, and related personal identifiable health information. The Student-Athlete's medical information should be used by the School District and Hospital Personnel for the purpose of determining the advisability of the Student-Athlete's participation in School District Athletic Events and/or any limitations on the Student-Athlete's participation. I understand that the Student-Athlete's health information is protected by the federal regulations under either the Health Information Portability and Accountability Act of 1996 (HIPAA) or the Family Educational Right and Privacy Act of 1974 (FERPA). 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 District Athletic Events, except to the extent relied upon for disclosures made prior to the automatic expiration.
- This Authorization is not intended to alter the Student-Athlete's ability to receive medical care from any health care provider.
- The Student-Athlete and Parent/Guardian understand that a copy of this signed agreement will be filed with the school for the duration of the current school year and that the Student-Athlete and/or Parent/Guardian may request a copy at any time.
- The undersigned understands and agrees that medical or health information disclosure by Hospital 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 my Student-Athlete's school Principal, Athletic Director, or the Athletic Trainer.

Student-Athlete Name (Print)

Parent/Guardian Name (Print)

Student-Athlete Signature

Parent/Guardian Signature

Date

DRUG SCREENING COMPLIANCE FORM

In an effort to protect the district's students and maintain the integrity of its interscholastic and extracurricular activities, the Rabun County Board of Education has adopted a policy requiring participation in a drug screening process for all high school students who participate in "privileged activities", defined as participation in interscholastic athletics, extracurricular activities and parking on school campus. All prospective participants in such activities must complete this form and return it with required signatures before the student will be permitted to try out for or participate in any privileged activity.

I understand that as a participant in a privileged activity at Rabun County High School, I am subject to all provisions of the school district's drug screening procedures. I agree to participate in the process and to the release of all drug screening results to the school district.

Signature of student

Date

Printed name of student

Activity

I am the parent/guardian of _____.
I understand that in order for my child to participate in any high school privileged activity, he/she will be subject to the drug screening process implemented by the Rabun County Board of Education. I have read and understand the procedures and agree for my child to participate in the process and for the results to be released to the school district.

Signature of parent/guardian

Date

Printed name of parent/guardian

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 _____ Signature of parent/guardian _____ 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 _____ Signature of parent/guardian _____ 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 <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 			
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 			
Lymph nodes			
Heart* <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 			
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 			
Lungs			
Abdomen			
Genitourinary (males only)?			
Skin <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Duck-walk, single leg hop 			

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
^bConsider GI 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 _____

Georgia High School Association

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 2022-2023 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: 4/22)



2.67 **Practice Policy for Heat and Humidity:**

- (a) Schools must follow the statewide policy for conducting practices and voluntary conditioning workouts (this policy is year-round, 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 at various heat/humidity levels.
 - (2) The ratio of workout time to time allotted for rest and hydration at various heat/humidity levels.
 - (3) The heat/humidity levels that will result in practice 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 readings 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 minimum duration of 3 minutes each during the workout.
- 82.0 - 86.9 Use discretion for intense or prolonged exercise; watch at-risk players 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 helmet, shoulder pads, and shorts during practice, 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 changing to 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 92.0 No outdoor workouts. Delay practice until a cooler WBGT level is reached.

- (c) Practices are defined as: the period of time that a participant engages in a coach-supervised, school-approved sport or conditioning-related activity. Practices are timed from the time the players report to the practice or workout area until players leave that area. If a practice is interrupted for a weather-related reason, the "clock" on that practice will stop and will begin again when the practice resumes.
- (d) Conditioning activities include such things as weight training, wind-sprints, timed runs for distance, etc., and may be a part of the practice time or included in "voluntary workouts."
- (e) A walk-through is not a part of the practice time regulation, and may last no longer than one hour. This activity may not include conditioning activities or contact drills. No protective equipment may be worn during a walk-through, and no full-speed drills may be held.
- (f) Rest breaks may not be combined with any other type of activity and players must be given unlimited access to hydration. These breaks must be held in a "cool zone" where players are out of direct sunlight.
- (g) When the WBGT reading is over 86, ice towels and spray bottles filled with ice water should be available at the "cool zone" to aid the cooling process AND cold immersion tubs must be available for the benefit of any player showing early signs of heat illness. In the event of a serious EHI, the principle of "Cool First, Transport Second" should be utilized and implemented by the first medical provider onsite until cooling is completed (core temperature of 103 or less).

Head Coach's Signature _____ Date _____

Athletes Name _____ Parent 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 2022-2023 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: 4/22)