



## Hart County Middle School Athletic Packet 2023-2024

Name on Birth Certificate (Last, First, MI) \_\_\_\_\_

Preferred Name \_\_\_\_\_

DOB \_\_\_\_\_ Grade \_\_\_\_\_ Sport(s) \_\_\_\_\_

Address \_\_\_\_\_

Mother/Guardian \_\_\_\_\_ Contact # \_\_\_\_\_

Work Contact # \_\_\_\_\_ Email \_\_\_\_\_

Father/Guardian \_\_\_\_\_ Contact # \_\_\_\_\_

Work Contact # \_\_\_\_\_ Email \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Claim/Policy # \_\_\_\_\_

Emergency Contact (Non-Parent/Guardian) \_\_\_\_\_  
Phone # \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Please list any injuries, allergies, or other medical history that you feel may be important in case of an emergency:

### Other

Is your child on any medication that is taken on a regular basis? (List)

My child may take any over-the-counter medication such as Tylenol, Advil, etc. or topical ointments such as Neosporin, hydrocortisone, etc. as needed **Yes** **No**

I grant permission for my son/daughter to practice and play in athletic events for HART COUNTY MIDDLE School. I will not hold the school responsible in any way whatsoever, except where negligence exists. I also grant permission for treatment deemed necessary for a condition arising during participation in the activity, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment.

Athlete's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_



**Protected Health Information Authorization**

**For Release of Information**

**School:** HCMS

I hereby authorize any medical provider associated with my school/organization, specifically PlaySafe to use and/or disclose my clearance and health recommendations to the athletic director, coaches, athletic trainers and medical personnel at my school/organization to inform them of my health status for the participation in athletics or activities. I understand that my refusal to sign this authorization may affect my child's ability to participate in athletics. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the state or federal law.

**Athlete's Printed Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Athlete's Signature if 18 or older:** \_\_\_\_\_

**Parent's Printed Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Parent/Guardian Signature:** \_\_\_\_\_

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

SCHOOL: HART COUNTY MIDDLE 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 **HART COUNTY MIDDLE 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 2023-2024 school year. This form will be stored with the athletic physical form and other accompanying forms required by the HART COUNTY CHARTER 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

**1. BY-LAW 2.67 - "Practice Policy for Heat and Humidity**

Schools must follow the statewide policy for conducting practices and voluntary conditioning workouts 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 level that will result in practice being terminated

A scientifically approved instrument that measures Wet Bulb Globe Temperature (WBGT) reading must be utilized at each practice to ensure that the written policy is being followed properly. **WBGT READING**

**UNDER 82.0** \_\_\_\_\_

**82.0 -86.9** \_\_\_\_\_

**87.0 - 89.9** \_\_\_\_\_

**90.0-92.0** \_\_\_\_\_

**OVER 92** \_\_\_\_\_

**ACTIVITY GUIDELINES & REST BREAK GUIDELINES**

Normal activities --Provide at least three separate rest breaks each hour of minimum duration of 3 minutes each during workout. Use discretion for intense or prolonged exercise; watch at-risk players carefully; Provide at least three separate rest breaks each hour of a minimum of four minutes duration each.

Maximum practice time is two hours. For Football: players restricted to helmet, shoulder pads, and shorts during practice. All protective equipment must be removed for conditioning activities. For all sports: Provide at least four separate rest breaks each hour of a minimum of four minutes each.

Maximum length of practice is one hour, no protective equipment may be worn during practice and there may be no conditioning activities. There must be 20 minutes of rest breaks provided during the hour of practice.

No outdoor workouts; Cancel exercise; delay practices until a cooler WBGT reading occurs

**GUIDELINES FOR HYDRATION AND REST BREAKS**

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

HART COUNTY HIGH SCHOOL ATHLETICS

PERMISSION TO PARTICIPATE/ BUS PERMISSION/ INSURANCE WAIVER/ HEAT PRACTICE POLICY/ MEDICAL RELEASE

EMERGENCY PROCEDURES

Law requires that permission be obtained for operative procedures on minors. This consent form should be signed by a parent or legal guardian so that procedures can be promptly carried out and no delays will occur with operative procedures. However, none will be performed except in an emergency situation without the parents or guardian being contacted and fully informed. By signing this permission form you give permission for first aid treatment and rehabilitation of minor injuries, to be conducted by a member of the Hart County High School coaching staff (Minor, professional medical help deemed unnecessary, (coach's discretion) injuries such as sprains, scrapes, bruises, etc... Parents will be contacted immediately if medical help is needed. Parents/guardians should understand that catastrophic injuries (brain, spinal cord, etc...) can occur in all sports. Hart county coaches will teach proper methods and techniques to help/hopefully prevent these from happening.

BUS PERMISSION

The student has permission to ride on a Hart county school bus to and from destinations under the supervision of a Hart County coach.

WAIVER OF ATHLETIC INSURANCE

One of the state requirements for athletic participation is adequate insurance coverage against injury while in practice or play. If you do not have adequate insurance coverage, you the parent/guardian are responsible for all medical expenses.

PLEASE READ THE ATTACHED HEAT/HUMIDITY POLICY MANDATED BY THE GEORGIA HIGH SCHOOL ASSOCIATION. By-Law 2.67

I give my permission to do an emergency operative procedure, emphasis on emergency, as declared by a medical doctor, knowing that all efforts have and are being made to contact the parent/guardian. Initial

I give my permission for my child to ride a county bus to and from games/practices. Initial

I (print parents name) am responsible for all medical expenses that may occur due to injury that may occur while participating in athletic activities. Initial

I have read and understand By-Law 2.67 of the GHSA on heat and humidity and the GHSA Concussion Policy By-law 2.68. Initial

My Son/daughter has an up to date cleared (by doctor) physical (1 year or less). Initial

\*\*\*\* Athletes Must Have a Current Physical to Participate \*\*\*\*

Physical are acceptable for 1 calendar year. Any physical taken after April 1st of the previous year will be good until the end of the following school year.

MY SON/DAUGHTER (print athletes name) HAS PERMISSION TO PARTICIPATE IN ATHLETICS, in any and ALL sports at Hart County for one calendar year.

I have read and agree to the Policies listed. PARENT OR GUARDIAN SIGNATURE DATE

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# Georgia High School Association Student/Parent Concussion Awareness Form

**SCHOOL:** HART COUNTY MIDDLE 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, HART COUNTY MIDDLE 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 2023-2024 school year. This form will be stored with the athletic physical form and other accompanying forms required by the*

## HART COUNTY CHARTER 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**

**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: \_\_\_\_\_

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  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

<b>GENERAL QUESTIONS</b> (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?				
<b>HEART HEALTH QUESTIONS ABOUT YOU</b>			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.				

<b>HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)</b>			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?				
<b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>			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 <i>Staphylococcus aureus</i> (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.**

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**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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2022 This form has been modified for use by the GHSA



# ■ 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 <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>		
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>		
Lungs		
Abdomen		
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>		
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 <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>		

<sup>a</sup> 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_