



# Heyward Gibbes Middle School

## Athletic Information Packet



We offer the following sports teams at Heyward Gibbes Middle School:

- Football
- Cheer
- Volleyball
- Wrestling
- Basketball (Girls & Boys)
- Track (Girls & Boys)x

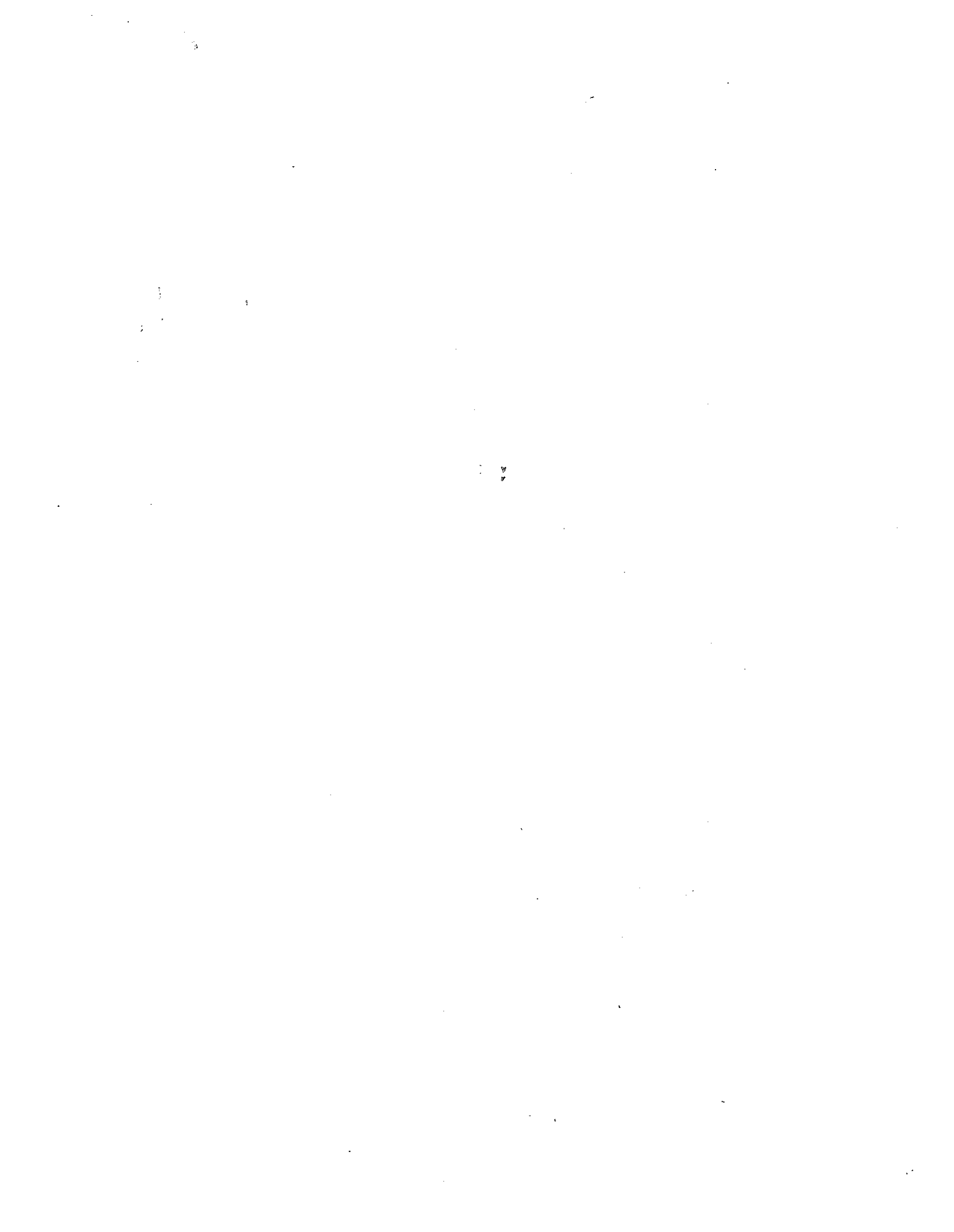
All students who want to participate in athletics at Heyward Gibbes Middle School must have the following information on file: (All forms are attached)

- Covid Waiver
- Proof of Current Physical (April 1, 2021 or later)
- Concussion Form
- Parent Permission Form
- Richland School District One Sports Health Form
- \$20 for Athletic Insurance

All of these items are mandatory in accordance with the policies of Richland School District One and the South Carolina High School League. All forms will be available in the main office. If you have any questions please contact Coach Seymore or Coach Mae at (803) 343-2942 or email us at [james.seymore@richlandone.org](mailto:james.seymore@richlandone.org) and [Marietta.wider@richlandone.org](mailto:Marietta.wider@richlandone.org).

Thank You

James Seymore  
Athletic Coordinator  
Heyward Gibbes Middle School



## Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

Name (please print) \_\_\_\_\_

As a parent or legal guardian of the above named student-athlete, I give permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of Athlete \_\_\_\_\_

\_\_\_\_\_ Date

Signature of Parent/Guardian \_\_\_\_\_

\_\_\_\_\_ Date



**INFORMED CONSENT, RELEASE OF LIABILITY, ASSUMPTION OF RISK FOR COVID-19**

\_\_\_\_\_ (Student Participant) desires to participate in the Richland County School District One ("District") athletic program. I, \_\_\_\_\_ (Parent/Guardian/Student 18 or older), for myself and my child, understand and agree as follows regarding risks associated with COVID 19 pandemic:

1. **Voluntary Participation:** I voluntarily elect for my child/Student Participant to access and use the District's premises, facilities, and equipment, and on other school districts' properties in the course of participating in the athletic activity, so that my child may participate in the District's athletic program. I voluntarily elect for my child/Student Participant to receive athletic instruction and training from District employees and volunteers. I understand that if I do not feel it is safe or appropriate to begin in-person workouts at this time, the student participant will be allowed to return to team activities without repercussions when I feel it is appropriate to do so, and the student participant may participate without mandatory attendance requirements during the summer period.

I understand that student participants who either have pre-existing medical conditions that place the Student Participant at higher risk of infection, or those who do not want to risk contracting COVID-19, should refrain from participating in high school sports at this time.

2. **Acknowledgment of Risk:** I warrant that I am fully aware of the inherent risks of infection from the COVID 19 virus and pandemic, among other communicable diseases, in all public spaces, and particularly in recreational facilities such as those used by the District for its athletic programs. I understand that use of the District's premises, or other premises and locations, and participation in athletic activities may result in an increased risk of exposure to COVID 19 because of, among other things, the sharing of equipment, close contact with other individuals during many athletic activities, and the prevalence of high touch surfaces inherently associated with the activities, the increased respiration and emission of respiratory droplets associated with physical exertion, the use of water bottles and other personal use objects, and the inherent and natural interaction and sharing behaviors of students.

I understand that COVID 19 is considered a highly contagious virus that may have serious health consequences that could result in prolonged hospitalization, permanent injury, and even death, and the potential spread to other individuals, including other household members, and I acknowledge that such risk cannot be fully mitigated or controlled.

3. **No Warranty:** I understand that the District will make reasonable efforts to comply with guidelines of South Carolina Department of Education, South Carolina High School League, Centers for Disease Control, South Carolina Department of Health and Environmental Control. However, the District cannot eliminate the risk of exposure to COVID 19, or guarantee that the facilities and athletic activities will be free of COVID 19; that faculty, staff, and volunteers will be or will remain free of infection; or that infected and contagious students or their families will not be present on the premises or participating in the activity. Accordingly, the District cannot and does not warrant, guarantee, or offer assurances that individuals will not be exposed to COVID 19 while on the premises or engaged in athletic activities, or that individuals will not then expose others to COVID 19.

4. **Assumption of Risk:** I understand and acknowledge that my or my child's access and use of the premises, facilities, equipment, and participation in the activities involve inherent risks to me or my child, and I understand the District has no control over these risks, nor the ability or duty to eliminate such risks, and even strict adherence to guidelines cannot eliminate risk. Consequently, for myself, and for my child, I assume such dangers, risks, and hazards by participating in athletic activities at this time.

~~5. Indemnification, Waiver, Release: I hereby waive, release, discharge, and hold harmless the District, including its employees, Board, directors/officials, officers, agents, and volunteers from any and all liability associated with any injury to the Student Participant, including personal injury or illness or even death, loss of income or educational opportunity, property damage, and all losses, damages, expenses, liabilities, or claims of any nature arising out of, related to, or in any way connected to the Student Participant use of the premises, facilities, and participation in the activities.~~

**6. Other Acknowledgements:**

- a. I represent that I have the authority to give this Informed Consent, Release of Liability, Assumption of Risk for the Student Participant's participation in the District's athletic program and use of District premises and facilities. I am the parent/legal guardian of the Student Participant, or I am 18 years of age or older, and have the unrestricted right to enter into this Informed Consent, Release of Liability, Assumption of Risk.
- b. I have received a copy of information on COVID 19, including FAQ Regarding Return to Team Sports and Guidelines for Return of High School Sponsored Team Sports and shall abide by them and make all reasonable efforts to equip and instruct my child to abide by them at all times while on the District's premises, or while otherwise engaged in the athletic activity, even on other districts' premises, for purposes of participating in the District's athletic program.
- c. I agree that in the event that the Student Participant or any member of our household tests positive for COVID 19, is informed by a health care provider that that the Student Participant or member of my household is likely symptomatic for COVID 19 infection, or otherwise becomes aware of information that a reasonable person should in good faith recognize as indicating exposure to COVID 19, I will immediately notify the District.
- d. I hereby give consent for emergency transportation and treatment in the event of illness or injury, and I accept responsibility for the payment of any emergency transportation or treatment on behalf of my child.
- e. To the best of my knowledge I further certify that my child is in good physical condition and has no medical or physical conditions that would restrict his/her participation in this event.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THIS INFORMED CONSENT, RELEASE OF LIABILITY, ASSUMPTION OF RISK; I FULLY UNDERSTAND ITS TERMS; I UNDERSTAND THAT I AM WAIVING RIGHTS BY SIGNING IT; AND I HAVE SIGNED IT FREELY AND VOLUNTARILY. I INTEND MY SIGNATURE TO BE A COMPLETE AND UNCONDITIONAL RELEASE OF LIABILITY TO THE EXTENT ALLOWED BY LAW.

\_\_\_\_\_  
Signature of Parent/Guardian for Minor Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Student Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent/Guardian

\_\_\_\_\_  
Print Name of Student Participant

\_\_\_\_\_  
Employee/Coach

\_\_\_\_\_  
Date

# Richland School District One Sports Health Form

## EMERGENCY CONTACT INFORMATION

(Please Print)

Athlete's Name \_\_\_\_\_ School \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ School Year \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone # \_\_\_\_\_ Cell/Business # \_\_\_\_\_ Email \_\_\_\_\_

Father's Name \_\_\_\_\_ Phone # \_\_\_\_\_ Cell/Business # \_\_\_\_\_ Email \_\_\_\_\_

In an EMERGENCY, if parents cannot be contacted notify:

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Cell/Business #: \_\_\_\_\_ Relationship \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone # \_\_\_\_\_ Family Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

## HEALTH INSURANCE INFORMATION

\*Do you have health insurance? Y / N      Do you have Medicaid? Y / N      Medicaid Number \_\_\_\_\_

Name of Company \_\_\_\_\_ Mailing Address \_\_\_\_\_

Insured's Name \_\_\_\_\_ Policy # \_\_\_\_\_

\*Richland School District One School Board Policy JLA – Student Insurance Coverage requires that all students participating in athletics and/or auxiliary sports-support related activities purchase accident insurance provided through the school district. Richland School District One carries athletic accident insurance on all its athletes, intended to be an "excess" policy designed to pay secondarily to the athlete's primary health insurance. In the event of injury, while participating as a part of a SCEISL sanctioned sports team representing Richland One, the athlete should seek the attention of the sports medicine staff as soon as possible. The athletic trainer (high school) or school official (middle school) will fill out the top portion of the insurance claim form (aka Notification of Injury Form). The parent/guardian should complete the claim form, follow the attached directions, and mail the completed form to the insurance company. \*Please note the claim must be filed within 90 days of injury.\*

I understand this information and will notify the head athletic trainer prior to the doctor's appointment if I require a claim form for an injury that meets the above requirements.

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

Date \_\_\_\_\_

## CONSENT FOR MEDICAL TREATMENT/RELEASE OF INFORMATION

I/We give consent for certified athletic trainers, coaches, and physicians to use their own judgment in securing medical aid and ambulance service in the case the parents/guardians cannot be reached. In the event of an accident requiring immediate medical attention, I hereby grant permission to physicians, certified athletic trainers, and/or appropriate healthcare professionals to attend to my son/daughter. It is understood that the school cannot be held responsible for any medical bills incurred because of illness or injury. Furthermore, I/We give permission for our son/daughter to be evaluated and treated by the school's certified athletic training staff and/or team physicians if he/she becomes injured while participating as an athlete in Richland One during the school year. I/We also authorize the school's sports medicine staff to be given medical information concerning my son/daughter by a physician or their staff. Likewise, the school's sports medicine staff may release medical information to physician's offices, coaching staff, nurses, administrators and faculty within Richland One as they see appropriate. I also commit to reporting ALL injuries to the Sports Medicine Staff, including but not limited to any symptoms related to a concussion. I also understand that the sports medicine staff will follow a return to play protocol for all injuries.

## CONSENT TO PARTICIPATE IN ATHLETICS AND RISK WAIVER

As the parent or legal guardian of the above named student-athlete, I give my permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular healthcare. I grant permission to nurses, certified athletic trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means.

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

Date \_\_\_\_\_

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

Date \_\_\_\_\_

A photocopy of this document shall serve as good as original.

## RICHLAND SCHOOL DISTRICT ONE

### Student-Athlete & Parent/Legal Guardian Concussion Statement

*\*If there is anything on this sheet that you do not understand, please ask a school staff member to explain it to you.*

*\*This form must be completed for each student-athlete, even if there are multiple student-athletes in each household.*

Student-Athlete Name: \_\_\_\_\_

Parent/Legal Guardian Name(s): \_\_\_\_\_

We have read the *Student-Athlete & Parent/Legal Guardian Concussion Information Sheet*.  
If true, please check box.

After reading the information sheet, I am aware of the following information:

Student-Athlete Initials		Parent/Legal Guardian Initials
	A concussion is a brain injury, which should be reported to my parents, my coach(es), athletic trainer, or a medical professional if one is available.	
	A concussion can affect the ability to perform everyday activities such as the ability to think, balance, and classroom performance.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach, athletic trainer, and/or a medical professional about my injuries and illnesses.	N/A
	If I think a teammate has a concussion, I should tell my coach(es), parents, athletic trainer or medical professional about the concussion.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	I will/my child will need written permission from a physician to return to play or practice after a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away right away. I realize that resolution from this injury is a process and may require more than one medical evaluation.	
	I realize that ER/Urgent Care physicians will not provide clearance for return to play from this injury on the day they are injured.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I understand that I will have to complete a graduated return to play and have written permission from a physician before I will be able to return to my sport per the school's concussion management policy.	
	I have read and received the concussion symptoms on the Concussion Information Sheet.	

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

PLEASE RETURN THIS COMPLETED FORM TO THE SCHOOL'S ATHLETIC DEPARTMENT



# 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
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	Yes	No
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 \_\_\_\_\_

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# 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 • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only) <sup>†</sup>			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic*			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
<sup>†</sup>Consider GU exam if in private setting. Having third party present is recommended.  
 †Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for \_\_\_\_\_
- Not cleared
- Pending further evaluation
  - For any sports
  - For certain sports \_\_\_\_\_
- Reason \_\_\_\_\_

Recommendations \_\_\_\_\_

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Signature of physician \_\_\_\_\_, MD or DO