

CONSENT TO TREATMENT

Dear Parent/Guardian:

In order to provide the best possible medical care for your child or ward (hereinafter, collectively, "child"), a medical record will be established for him/her. If your child should become injured while playing sports, this record will provide important information about him/her. Please complete and sign as indicated and return to your child's coach. Your signature serves as permission to treat your child until 18 years of age or until he/she has completed activity participation.

**THIS INFORMATION MUST BE COMPLETED BEFORE YOUR CHILD CAN BE EVALUATED
/ TREATED FOR ANY INJURY THAT MAY OCCUR**

Athlete Name: _____ D.O.B. ____/____/____ Grade - _____

Athlete Address: _____

Parent/Guardian Name: _____

Parent/Guardian Address: _____

Home/Cell Phone: _____ Work Phone: _____

Guaranteed contact number - Pager, Cell Phone, etc. _____

INSURANCE INFORMATION

Primary:

Secondary:

Company Name: _____

Company Name: _____

Policy and/or Group No.: _____

Policy and/or Group No.: _____

ALLERGIES/MEDICAL CONDITIONS

My child's doctor is: _____

My child is currently taking the following medications: _____

My child has the following medical conditions: _____

My child has the following allergies: _____

PARENTAL CONSENT

The undersigned grants consent to Thomas County Schools, and to their respective employees, for the child listed above to receive an assessment and the treatment of any injuries he/she may suffer during the school year. Injury treatment would include the application of modalities such as cold, heat, electrical muscle stimulation and/or ultrasound if necessary, as well as therapeutic exercises, to safely speed recovery and return to activity.

MEDICAL RELEASE

I, the undersigned, give permission for school officials, chaperons, or representatives of Thomas County Schools involved in the activity with my child to seek medical attention or render first aid if such attention is necessary at the discretion of the said person involved. In case of emergency, and when I cannot immediately be contacted, I give permission to the physician selected by the school officials to hospitalize, secure proper treatment, order injections, anesthesia, or surgery for my child.

I UNDERSTAND THAT IN THE EVENT OF SERIOUS INJURY OR SUDDEN ILLNESS OCCURRING TO MY CHILD, EVERY PRUDENT EFFORT WILL BE MADE BY THE SCHOOL AND/OR MEDICAL OFFICIAL TO CONTACT ME. IF I CANNOT BE CONTACTED, THIS DOCUMENT (OR PHOTOCOPY) WILL SERVE AS MY PARENTAL OR GUARDIANSHIP CONSENT. I give my permission to the health care providers of the Thomas County Schools Sports Medicine team (Physicians, ATCs, Nurses, medical personnel, Archbold rehabilitation and hospital staff) to perform physical examinations and treatments of sports related injuries including, but not limited to, first aid, manual therapy, splinting and bracing, providing OTC medications, use of modalities, and execution of life-saving procedures. I understand that by signing this form, I am authorizing them to treat my child for as long as they deem necessary and appropriate or until I withdraw my consent in writing.

ACKNOWLEDGEMENT OF RISK

Both the student and the parent/guardian should read this statement carefully. You should be aware that playing, practicing, conditioning and preparing for participation in any sport can be a dangerous activity involving risks of injury. The dangers and risks of sports participation include, but are not limited to: death, serious neck, head and/or spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, tendons, and other aspects of the body, general health and well being. Because of the dangers of participating in sports, the student should recognize the importance of following coaches' instructions regarding playing techniques, training, and other teams' rules and obey such instruction.

ASSUMPTION OF RESPONSIBILITY

It is my desire that my child participate in such athletic activities for which the within Consent to Treatment, Medical Release and Acknowledgement of Risk is being given by me as the parent or legal guardian of such child and as a precondition to my child's participation in such athletic activities. I fully understand the importance, consequences and effects of the within Consent to Treatment, Medical Release and Acknowledgement of Risk that I am entering into on behalf of myself and on behalf of my child, I have fully disclosed any medications, allergies or medical conditions that my child may have, and I assume full responsibility for any action taken in reliance upon the provisions hereof.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE ABOVE.

SIGNATURE OF PARENT/GUARDIAN

DATE

Printed Parent's/Guardian's Name

SIGNATURE OF ATHLETE

DATE

Printed Athlete's Name



**LIABILITY RELEASE and LIMITED POWER OF ATTORNEY
For participation in off-campus activities and field trips sponsored by the
Thomas County School District**

I, (insert parent/guardian's name) _____, the undersigned, in order for my child (insert child's name) _____ to participate in off campus activities and field trips sponsored by the Thomas County School District, do hereby state and agree as follows:

1. In consideration of permission being granted to my child to participate in field trips and activities being sponsored by the Thomas County School District, I am entering into this release agreement which extends to the Thomas County School District, its agents, employees, volunteers, representatives, successors or assigns, both individually and in any capacity, (hereinafter referred to as releasees).
2. Any chaperone appointed by the Thomas County School District or its designee has my permission to authorize emergency medical care for my child. My religious beliefs do not preclude any medications or normal emergency procedures. My health insurance company and policy number are:

Ins. Co. _____
Policy No. _____

In case of emergency, I can be reached at the following numbers:
_____ or _____

3. I do further and hereby constitute and appoint any chaperone appointed by the Thomas County School District as my attorney-in-fact to make any and all decisions which he or she believes to be in my child's best interest as to the obtaining of emergency medical care. I further agree to be liable for any and all the expenses incurred by my attorney-in-fact while he or she is acting under the provisions of this instrument.
4. I understand that I will be responsible for the costs of any medical treatment provided to my child, and the chaperone(s) are authorized to sign any necessary documentation as my attorney-in-fact at any medical facility providing medical services for my child.
5. I hereby grant Thomas County School District and its agents full authority to take whatever actions they may consider to be warranted under the circumstances regarding my child's health and safety, and I fully release them from any liability for such decisions or actions as may be taken in connection herewith. I further agree to be liable for any and all the expenses incurred by my attorney-in-fact while he or she is acting under the provisions of this instrument. I understand that I am responsible for my child's medical insurance coverage.

Parent/Guardian Signature

Date

Witness

Date

Note: Please complete the front and back of this form.



Medical Information
(Please Print)

Name of Student: _____

1. Known drug allergies: _____

2. Last Tetanus administration received: _____

3. History of heart condition, diabetes, epilepsy, or rheumatic fever: (please describe)

4. Medication currently taking: _____

5. Any physical restrictions: _____

6. Other conditions: _____

7. Name of family physician and telephone number: _____

8. Closest relatives' name and telephone number: _____

Home Phone

Work Phone

Please have your child know and understand the Code of Conduct located in the student's handbook– any person violating these rules may be sent home at his or her own expense, cause participants from the school to be sent home, or otherwise disqualify the school from participation in the activity.

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 upcoming 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

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 upcoming 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



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 _____