

Physical Expiration Date: \_\_\_\_\_



**LANGSTON CHAPEL MIDDLE SCHOOL**  
**ATHLETIC DEPARTMENT**  
156 Langston Chapel Road  
Statesboro, Georgia 30458



**PERMISSION FORM FOR ATHLETIC PARTICIPATION 2024-2025**

I, (Parent or legal guardian) of \_\_\_\_\_, am granting  
(student name)  
permission to tryout or participate in any interscholastic activities at LCMS except:

I have read, understand and acknowledge the following statements about participation in athletic activities:

1. While participating in interscholastic sports, he or she is to obey all rules and regulations set forth by the Bulloch County School System and Langston Chapel Middle School.
2. I understand that the physical examination is good for one school year.
3. I give permission for him or her to participate in practices and drills in preparation for interscholastic competition, realizing that such activities could result in injury. I acknowledge that even with proper supervision, the best coaching, and the best equipment that injuries are still possible. On very rare occasions, these injuries can be so severe as to cause paralysis, disability, or death.
4. I give permission to the school official(s) to seek immediate medical attention if such attention is necessary.
5. I give permission for him or her to be transported by school officials, and/or adult chaperone(s) on Bulloch County School System buses to scheduled events.
6. I understand that my child may only be picked up from an event by the parent or guardian. No sister, brother, uncle, aunt, grandparent, or other relative has legal guardianship of your child.
7. I, the parent/guardian, accept on behalf of my child, and assume any risks and all responsibility for losses, costs, and damages I incur or my child incurs as a result of my participation in the activity.
8. I understand that the athletic department at Langston Chapel Middle School is not providing insurance for my son/daughter in case of injury. I further understand that it is my responsibility to purchase school day insurance if I desire to have insurance coverage on my child other than what I already have.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Cell Number

\_\_\_\_\_  
Work Number

Langston Chapel Middle School  
Athletic Department  
156 Langston Chapel Road  
Statesboro, Georgia 30458

CHILD'S NAME: \_\_\_\_\_

LCMS  
INSURANCE INFORMATION  
2024-2025

Please check one of the following:

- ☐ 1. I have personal insurance and assume all responsibility for medical costs.

Name of Insurance Company \_\_\_\_\_

Policy Number (Must be Included) \_\_\_\_\_

- ☐ 2. I have no personal insurance but will assume all responsibility for medical costs.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

# Optim Sports Medicine

## Parent/Guardian Consent & Release Form

In order to provide the best possible medical care for your child, a medical record will be established for him/her. If your child should become injured while playing sports, this form will provide important information to coaches and medical personnel. Please complete and sign as indicated

### Emergency Contact Information

Student's Name (Legal) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Last First MI

Student's Preferred Name \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Current Class: \_\_\_\_\_ HS Graduation Year: 20 \_\_\_\_

Address: \_\_\_\_\_, GA \_\_\_\_\_  
Street City ZIP

Student's Home Phone # (\_\_\_\_) \_\_\_\_ -- \_\_\_\_

Student's Cell Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Child Lives With: \_\_\_\_\_

Father/Guardian's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Father/Guardian's Cell Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Work # (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Mother/Guardian's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Mother/Guardian's Cell Phone # (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work # (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Parent/Guardian Contact E-Mail Address: \_\_\_\_\_

Emergency Contact (must be 21 or older): \_\_\_\_\_

Relationship: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Office Phone #: \_\_\_\_\_

### Insurance Information

Primary Insurance Co: \_\_\_\_\_ Name Of Policy Holder: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Customer Service Phone #: \_\_\_\_\_ EXT: \_\_\_\_\_

**\*\*PLEASE BE AWARE OF THE FOLLOWING WHEN CARING FOR YOUR CHILD\*\***

Medical Conditions: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications & Condition: \_\_\_\_\_

**PERMISSION FOR AUTHORIZATION TO TREAT IN PARENT'S ABSENCE**

*\*I give permission for school representatives to authorize medical treatment for my child in my absence. This may include, but is not limited to, activation of emergency services, emergency room procedures, and injury/illness evaluation treatment by certified athletic trainers at away competitions.*

Print Parent Name : \_\_\_\_\_ Parent Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*\*Please complete/sign/date every line(if applicable) in order for your student athlete to be eligible to participate.*

**ATHLETIC TRAINING & COMPETITION PARTICIPATION: Parental Consent and Insurance Information.**

**Warning:** Although participation is supervised interscholastic athletics and school activities may be one of the least hazardous in which students will engage in or out of school, BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS AND SCHOOL ACTIVITIES INCLUDES RISK OF INJURY, WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC INJURY, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH. Although serious injuries are not common in supervised school athletic programs or the school setting, it is possible only to minimize, not eliminate, risk. Students can and do have responsibility to help reduce the potential for injury. STUDENTS AND PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR TEACHERS/COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR EQUIPMENT DAILY.

By signing this consent form, you acknowledge that you have read and understand this warning. PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THE FORM.

I/We hereby give consent for my/our child to:

1. Compete in athletics in the Georgia High School Association.
2. Accompany any school team/activity on any of its local or out-of-town trips.
3. Verify that the information on this form on this form is correct and understand that any false information may result in my son/daughter being declared ineligible to participate.

I further acknowledge and consent to the Internet storage and delivery of this information by Optim Sports Medicine and its affiliated vendors to medical providers, as appropriate. This acknowledgement of risk and consent to allow participation shall remain in effect until revoked in writing.

**Authorization to Release Medical Information**

I, being of lawful age, hereby authorize and consent to having Optim Sports Medicine Program Athletic Trainers and/or their consulting physician(s) provide any requested medical information to other physicians, healthcare providers, highschool coaches or school administration, intercollegiate teams, professional teams, scouts, recruiters, or athletic trainers that directly pertains to my participation at *Langston Chapel Middle School*. Said authorization to release medical information will include, but not limited to, information

concerning illnesses, injuries, treatments, hospitalizations, examinations, X-rays, or other forms of diagnostic testing occurring while participating in activities at said school or athletic organization.

I understand that I may revoke this authorization by providing written notice to Optim Sports Medicine. I also understand that I am authorizing access to the student's medical records and patient identifiable information by executed this release.

This authorization shall be valid for one (1) year commencing on the effective date executed below. I understand that the release of my medical information is being carried out with my consent and so assume full responsibility.

### **MEDICAL CONSENT TO TREAT**

I hereby grant parental consent to Optim Sports Medicine for assessment/treatment of any injuries my child may suffer during the school year in the course of athletic training competition.

I give permission for school officials, chaperones, or representatives of Optim Sports Medicine overseeing the athletic training or competition in which my child is participating to seek medical aid render first aid if such attention is necessary, at the sole discretion of such individual. In case of emergency and when I cannot be immediately reached by telephone or otherwise, I give permission to the physician selected by school officials to hospitalize, secure proper treatment, and other injections, anesthesia, or surgery for my child. I agree to be responsible for all medical expenses incurred in connection therewith. In the event the school incurs expenses for medical treatment, I agree to reimburse school in full.

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

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Relationship to Student**

# 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 2023-2024 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 \_\_\_\_\_

# 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 2023-2024 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**



## ■ 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

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

(First Name)

(Last Name)

GENERAL QUESTIONS (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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

**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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2023 This form has been modified for use by the GHSA



## ■ PREPARTICIPATION PHYSICAL EVALUATION

### PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
(First Name) (Last Name)

#### 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>	<input type="checkbox"/>	
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
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>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder and arm	<input type="checkbox"/>	
Elbow and forearm	<input type="checkbox"/>	
Wrist, hand, and fingers	<input type="checkbox"/>	
Hip and thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg and ankle	<input type="checkbox"/>	
Foot and toes	<input type="checkbox"/>	
Functional <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>	<input type="checkbox"/>	

<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: \_\_\_\_\_