CHATHAM SPORTS MEDICINE & PHYSICAL THERAPY

School Year 2024-2025

EMERGENCY CONTACT & INSURANCE INFORMATION

Student's Name (Legal)_____,_____, _____
LAST FIRST MI

D.O.B_____/_____/_____ **2024-2025 Grade Level:** _____

Address: _____, **GA** _____
STREET CITY ZIP

Student's Home Phone #: _____ **Student's Cell Phone #:** _____

Child Lives With: _____ Father _____Mother ____Both _____ Other: _____

Father/Guardian's Name: _____ **Home Phone #(_____)_____-_____**

Father/Guardian's Employer: _____

Father/Guardian's Cell Phone # (_____)_____-_____ Work Phone # (_____)_____-_____ext_____

Mother/Guardian's Name:_____ **Home Phone#(_____)_____-_____**

*Mother's Employer:*_____

Mother/Guardian's Cell Phone # (_____)_____-_____ Work Phone # (_____)_____-_____ext_____

Parent/Guardian contact e-mail address: _____

Emergency Contact & Relationship (must be 21 or older): _____

Contact Home Phone # (_____)_____-_____ Contact Cell Phone # (_____) _____-_____

Primary Physician: _____ **Office Phone # (_____)_____-_____ext_____**

INSURANCE INFORMATION

Primary Insurance Co: _____ **Name of Policy Holder:** _____

Policy #: _____ **Group #:** _____

Insurance Co. Phone # (_____)_____-_____ext _____

PLEASE BE AWARE OF THE FOLLOWING WHEN CARING FOR MY CHILD

Medical Conditions: _____
Allergies: _____
Medications & Condition: _____

PERMISSION FOR AUTHORIZATION TO TREAT IN PARENT ABSENCE

*I give permission for representatives of Savannah Chatham County Public School System 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 and treatment by certified athletic trainers at away competitions.

Print Parent Name:_____ **Parent Signature:**_____ **Date:**_____

PLEASE ATTACH COPY

(FRONT/BACK) OF

STUDENT'S

INSURANCE CARD*

School Year 2024-2025

PERMISSION & MEDICAL RECORD RELEASE FORM

Student's Name: _____

Last **First** **M.I.**

ASSUMPTION OF RISK AND PERMISSION TO TREAT

I am aware playing or practicing to play/participate in any sport or sport related activity could be a dangerous activity involving **MANY RISKS OF INJURY**. I understand that the dangers and risks of playing or practicing to play/participate in sports or sport related activity include, but are not limited to: death; serious neck and spinal injuries that may result in complete or partial paralysis; brain damage; serious injury to virtually all bones, joints, ligaments, muscles, tendons, other aspects of the musculoskeletal system and vital organs; and serious impairment to other aspects of the body, general health, and well-being. I understand the dangers and risks of playing or practicing to play/participate in any sport or sport related activity may result not only in serious injury, but in a serious impairment of my (the participant's) future abilities to earn a living; to engage in other business, social, and recreational activities; and generally enjoy life. Because of the dangers of playing or practicing to play/participate in any sport or sport related activity, I recognize the importance of following the coach's, official's and medical staff's instructions regarding playing techniques, training, and other team rules, etc., and agree to obey such instructions.

As the parent / legal guardian of the above named participant, I have read the above warnings and release, and understand its terms. I hereby agree to hold the Savannah Chatham County Public School System, its direct and contracted employees, agents, representatives, coaches and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of every kind and nature whatsoever that may arise by or in connection with participation of my child in any activities related to Savannah Chatham County Public School System activities. The terms hereof will serve as a release for my heirs, estate, executor, administrator, assignees, and for all members of my family. Whenever injury and/or sickness occur to the participant listed above, and the participant is under the supervision of Savannah Chatham County Public School, and the participant's parent / legal guardian is unavailable to give his/her permission for treatment, the participant and others whose signatures are attached below do hereby give permission to Chatham Orthopaedics Sports Medicine to authorize any emergency action necessary to ensure the safety of the child. The intention hereof being to grant authority to administer and perform all and singularly any examinations, pre-participation physical examinations, treatments, anesthetics, operations, and diagnostic procedures which may now, or during the course of this participant's care, be deemed advisable or necessary. This does not hold Chatham Orthopaedics and/or the Savannah Chatham County Public School System financially responsible for any medical care given. An insurance policy may be available through the school for an additional cost.

I specifically acknowledge that **Football** and **Wrestling** are **collision sports** that involve an even greater risk of injury than **contact sports: Basketball, Baseball, Cheerleading, Lacrosse, Soccer, Softball, and Volleyball** which involve greater risk of injury than **non-contact sports: Bowling, Cross Country, Equestrian, Golf, Rowing, Swimming, Track & Field and Tennis.**

_____ ___/____/_____ _____ ___/____/____

Student's Signature Date Parent /Guardian Signature Date

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

General Disclosure:

I hereby authorize Chatham Orthopaedics Sports Medicine Medical Personnel to release information from my medical records for the purpose of payment, treatment or operations to their Business Associate Partner (which includes; the Attending School's Coaching Staff and Administrators) and any Hospital in case of an Emergency Situation. This authorization shall be valid for the duration of the 2024-2025 school year. It is subject to revocation by the patient, or the parent / guardian at any time except to the extent that action has been taken in reliance thereon. I am aware that once Chatham Orthopaedics Sports Medicine discloses this information per my instructions, the information is subject to re-disclosure and may no longer be protected by the HIPAA (Health Insurance Portability and Accountability Act) of 1996. I understand that a photocopy of this authorization shall be as valid as the original. I know that I, or my authorized representative may receive a copy of this authorization upon request.

_____ ___/___/____ _____ ___/____/_____

Student's Signature Date Parent/Guardian Signature Date

GHSA: HEAT & HUMIDITY POLICY

Heat and Humidity Awareness:

GHSA has a statewide practice policy for extremely high heat and humidity that list guidelines for monitoring the heat during sports that occur in the warmer months. This includes practices, games, and voluntary conditioning.

GUIDELINES FOR HYDRATION AND REST BREAKS:

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

Please refer to BY-LAW 2.67-GHSA Practice Policy for Heat and Humidity for more details:
https://www.ghsa.net/sites/default/files/documents/sports-medicine/HeatPolicy2018.pdf

It is recommended that all guidelines be followed in such a way that the best interests of our students be made our number one priority. It is also recommended that coaches constantly teach our students about proper hydration throughout each day. It is important that student-athletes be allowed to carry water with them during the day and hydrate themselves, on days of practices and games, while the weather has the possibility of reaching critical levels in relation to the heat and humidity.

I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.

_____ _____

Student Athlete Signature ***Date***

_____ _____

Parent/Guardian Signature ***Date***

CHATHAM SPORTS MEDICINE & PHYSICAL THERAPY

CONCUSSION AWARENESS INFORMATION AND GUIDELINES

The purpose for this document is to provide crucial information for student-athletes and parents/legal guardians. This form must be signed by both the athlete and parent/legal guardian prior to tryouts, workouts or other forms of participation.

Concussion Awareness Information:

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 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.

COMMON SIGNS OF A 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.)

Student-Athlete Concussion/Head Injury Guidelines:

I affirm that:

- It is my responsibility as a student athlete or as the parent/legal guardian of a student athlete to report all injuries and illnesses to my Athletic Trainer or Chatham Orthopaedics Sports Medicine representative.
- I have fully disclosed, in writing, all prior head injury related events and medical conditions and will disclose any future conditions to my Athletic Trainer or Chatham Orthopaedics Medicine representative.
- I understand the importance of and will immediately report any and all signs and symptoms of a head injury, including concussion, to the Chatham Orthopaedics Sports Medicine representative or my Head Coach.
- I understand there is the possibility that participation in any sport may result in a head injury and/or concussion.
- If there are questions or I wish to discuss any areas and issues that are not clear to me concerning head injuries, I have the contact information of a Chatham Orthopaedics Sports Medicine Athletic Trainer.
- I acknowledge that no piece of equipment can prevent injury/illness/concussion. Specifically, helmets or soccer headbands may help to prevent catastrophic head injury but do not significantly reduce the risk of a head injury, including concussion. I understand that it is my responsibility to wear (or to ensure the student-athlete wears) any equipment issued to me (or the student-athlete) in the appropriate manner.
- I agree to read and abide by all warning labels on any equipment before use.
- I have read and reviewed the following statement released by the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

An athlete who sustains a concussion will be required to sit out from activity **and** obtain a return to full athletic participation clearance from one of the following qualified medical practitioners (MD, DO, NP). Athletes that are neurodivergent (ie: have an IEP, are autistic, etc) must obtain clearance from a Neurologist. If athlete was also referred for physical therapy, the referring Physical Therapist (PT) must also send clearance documentation.

I have been provided with and understand the Chatham Sports Medicine Concussion Protocol which is in accordance to By-Law 2.68: GHSA Concussion Policy.

BY SIGNING I AFFIRM THAT I HAVE READ THIS FORM AND I UNDERSTAND ALL THE FACTS PRESENTED IN IT.

_____ _____

Student Athlete Signature ***Date***

_____ _____

Parent/Guardian Signature ***Date***

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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ 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: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ 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		
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 _____

HE0503 9-2681/0410

Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name _____ Date of birth _____

PHYSICIAN REMINDERS

1. 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?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ 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[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]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

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

  Reason _____

Recommendations _____

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

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

Other information _____