



Parent(s) and/or Guardian(s):

East Georgia Healthcare Center offers healthcare services at your child's school through our school-based clinic. The clinic gives your child an opportunity to be evaluated by a licensed healthcare provider without having to miss a great deal of class time. Parents and/or guardians do not need to be present during the visit, but a signed consent form is required for examinations & treatment. We will notify and obtain verbal consent from parents or guardians before each visit if they are not present. After each visit, you will be contacted again to review the examination and address any questions you may have. To ensure timely service, please keep your contact information up to date. Full summaries of the visit will be sent through our secure patient portal.

Description of Services

A sliding fee scale is offered for patients without insurance, however, if you do have insurance this will be billed at the time services are provided to your child. Any co-pays or deductibles for students will be billed to the parent or guardian by mail.

The following services are provided:

- Preventative medicine services such as Well Child Physicals
- Same day sick visits
- Sports physicals, vaccinations, prescriptions, lab testing, referrals, and follow up care
- Administration of medication for health problems as appropriate
- Chronic condition and medication management
- Mental health counseling

Staff Contact Information & Health Center Hours

East Georgia Healthcare Center strives to provide exceptional care for your children and family. If you have any questions, please feel free to contact us at **(478) 494-9926**.

Hours of Operation and Service Locations

We are open daily following the school calendar.

Twin City Elementary
Monday & Tuesday 8:00am-4:15pm

Emanuel County Institute
Wednesday - Friday 8:00am-4:15pm

Jenkins County Schools
Monday - Friday 8:30am - 2:30pm

Langston Chapel Schools
Monday - Friday 8:00am – 4:00pm

Treutlen County Schools
Monday 8:00 am-6:00 pm
Tuesday - Thursday 8:00 am-5:00 pm
Friday 8:00 am-3:30 pm
Closed Daily for Lunch 12:00pm-1:00pm

Swainsboro Elementary School
Monday 8:00am-4:00pm
Tuesday 8:00am-4:00pm
Wednesday 8:00am-5:00pm
Thursday 8:00am-4:00pm
Friday 8:00am-3:30pm

***Please keep this page for reference**



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 2024-2025 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

ENROLLMENT & CONSENT FORM

East Georgia Healthcare Center

Phone (478) 494-9926

STUDENT INFORMATION

Student Name: _____ School of Attendance: _____ Grade: _____

Address: _____ Birth date: _____

City/State/Zip: _____

Student SS#: _____ Email: _____ Cell: _____

☐ **I have completed the demographic update on the Patient Portal or have visited the clinic to complete the necessary forms as instructed for services with East Georgia Healthcare Center.*

PARENT / GUARDIAN INFORMATION

Father: _____ Phone (H) _____ (W) _____ (C) _____ Email _____

Mother: _____ Phone (H) _____ (W) _____ (C) _____ E-mail _____

Guardian: _____ Phone (H) _____ (W) _____ (C) _____ E-mail _____

Alternate Contact:

Relationship to the child _____

Name _____ Phone (H) _____ (W) _____ (C) _____ E-mail _____

Alternate Contact:

Relationship to the child _____

Name _____ Phone (H) _____ (W) _____ (C) _____ E-mail _____

CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES

I, the parent/guardian of said student, give consent for my child to receive services at the school-based health center. I understand that this consent form is valid for the duration of my child's education in a public school system served by EGHC or until I provide the healthcare center staff with written directions otherwise.

All healthcare information is confidential. By signing the consent form, you are giving the healthcare center, school nurse, and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay. As in any health center, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing purposes.

Confidentiality between the student, parents, and the health center is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions. I am the legal guardian of the above-named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above-named child will be shared between the medical provider and the alternative contact.

Signature of Parent / Legal Guardian

Date

**east georgia
healthcare center**
PATIENT INFORMATION

Patient's Full Name: _____ Date of Birth: _____ SSN: _____ - -

Mailing Address: _____
City _____ State _____ Zip Code _____

Physical Address: _____
City _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone: _____ Preferred Pharmacy: _____

I would like to receive appointment reminders and/or test results by (Circle One of Each) Cell or Home Text or Voice

Preferred Number (Circle One): Home Cell Other Email:

Race (Check all that apply): White Black/African American Asian Indian Chinese Filipino Japanese Korean Vietnamese Other Asian
American Indian/Alaska Native Native Hawaiian Other Pacific Islander Guamanian or Chamorro Samoan Choose not to disclose

Ethnic Background (Check all that apply): Non-Hispanic/Latino Cuban Mexican Mexican American Chicano/a
Puerto Rican Another Hispanic/Latino/Spanish Origin _____ Choose not to disclose

Preferred Language: (Circle One): English Spanish Other (please specify) _____

Gender at Birth (Circle One): Male Female Unknown

Housing Status: Homeless? [] Yes [] No Resident of Public Housing? [] Yes [] No

Student Status: (Circle One): Full-Time Part-Time Not a student Are you a veteran? [] Yes [] No Disabled? [] Yes [] No

Marital Status (Circle One): Single Married Divorced Separated Widowed

GUARANTOR INFORMATION

If other than Mother or Father, please provide a copy of custody paperwork.
We consider the person completing this form to be financially responsible for patient.

Person Completing This Form (Circle One): Self Mother Father Legal Guardian Other (specify): _____

Name: _____ Date of Birth: _____ SSN: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____

Employment Status:(Circle all that apply) Full-Time Part-Time Not Employed Self-Employed Retired Military-Active Military-Reserve

Annual Household Income: [] \$15,960 or less [] \$15,961 - \$23,940 [] \$23,941 – \$31,920 [] \$31,921 or more

1. Have you or anyone in your family performed any type of farm work in the last two (2) years? [] Yes [] No
2. If yes to #1, have you or a member of your family ever moved somewhere to do farm work? [] Yes (migrant) [] No (seasonal)
3. If yes to #1, have you or anyone in your family stopped migrating to work in agriculture because of a disability or age? [] Yes [] No

Emergency Contact Information

Name: _____ Relationship to Patient _____

Mailing Address: _____ City _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone _____ Email _____

Insurance Information

Choose all that apply: ☐ I am uninsured ☐ I am insured ☐ I have private insurance ☐ I have Medicaid ☐ I have Medicare

I don't have insurance and I would like information about affordable insurance options and enrollment ☐ Yes ☐ No

Primary Insurance Company: _____ ID# _____ Policy Holder Name: _____
Secondary Insurance Company: _____ ID# _____ Policy Holder Name: _____

Payment is expected at the time of service. If you have insurance, we will file your claim as a courtesy; however, your insurance policy is a contract between you and your insurance company, not between EGHC and the insurance company. If your insurance does not pay all or part of your claim, you, the patient, will be billed for the remaining balance and are responsible for ensuring payment is made.

Patients without insurance are responsible for paying in full at the time of service.

By signing below, you authorize EGHC to submit claims to your insurance company (if applicable) and acknowledge that you are financially responsible for any remaining balance.

Are you interested in applying for our sliding fee discount program?

YES NO Currently enrolled

Patient or Responsible Party's Signature

Date



HIPAA – Authorization of Protected Health Information

I _____ give permission for the following person(s) to participate in the
(Patient/Parent's/Guardian's Name if under 18)

care of _____ while treated by the staff of East Georgia Healthcare Center.
(Patient's Name)

I authorize the following person(s) to accompany the patient to the office, to participate in their medical care to be provided in the office, to pick up prescriptions for the patient, and/or access patient record(s) if they're unable to do so personally. A picture ID will be required.

Patient's Date of Birth _____

Name/Relationship/Phone number	Allowed to accompany patient (and make medical decisions if patient is a minor):	Allowed to pick up prescriptions:	Allowed to access ALL patient records:	Allowed to access all patients records excluding mental/behavioral health and/or Substance Use Disorder (SUD)
	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No
	Yes No	Yes No	Yes No	Yes No

*****If there are specific encounters or record types you wish to remain confidential please discuss that with your provider or nurse.*****

Prescription delivery: I authorize EGHC pharmacy to deliver my/my dependent's prescription medication as requested. Home _____ Work _____ EGHC Clinic _____

Patient /Parent's /Guardian's Signature

Date Signed

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION INCLUDING ANY SUBSTANCE USE DISORDER RECORDS ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Center may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Center or the hospital. For example, we may disclose medical information about you to people outside the Center who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Center and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Center personnel for review and learning purposes. For example, we may review your record to assist with our quality improvement efforts.

NOTE: Use and disclosures described above as they relate to Substance Use Disorder (“SUD”) records require your specific consent at the bottom of this form before we can utilize them for treatment, payment or healthcare operation purposes (“TPO”). You can sign one form to permit all future uses and disclosure for TPO purposes, or you can restrict your consent to each individual disclosure. Examples of how your SUD information is used or disclosed upon our consent is consistent with the examples set out above. You should be informed that the requirement for your consent for TPO is specific to us. Once any SUD records are released to another HIPAA covered entity or business associate, they are permitted to redisclose records in accordance with HIPAA regulations.

For Appointment and Health Reminders. We may contact you by telephone, text or email to remind you of your scheduled appointments or recommended services.

WHO WILL FOLLOW THIS NOTICE. This notice describes our Center's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Center personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Center. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Center, whether made by Center personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Current law permits us to include any SUD records in your treatment record with other treatment therapies. **Other ways we may use or disclose your protected healthcare information include appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; and others; public health risks; and worker's compensation.

**Other than releasing SUD records to a coroner or medical director without specific consent and to public health authorities, provided that the records disclosed are de-identified according to standards established in the HIPAA Privacy Rule, your written consent is required for the other types of disclosure mentioned above, i.e., research, fundraising, avert a serious threat to health or safety except in emergency situations, law enforcement, military and veterans, national security and intelligence activities, organ and tissue donations; and other public health risks and workers' compensation. Any SUD records may not be used as records and testimony in civil, criminal, administrative and legislative proceedings absent your written consent.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Center. To request an amendment, your request must be made in writing and submitted to the Privacy Officer, and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations (SUD records require your specific written consent) You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Except as to SUD treatment, *we are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Center For any SUD related treatment, you must provide your written consent to be included in fundraising activities.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full. Disclosure of SUD records to a health plan require your written consent.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing, and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you (for SUD disclosures, your request can include the prior three years). To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Center's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Center or with the Secretary of the Department of Health and Human Services. To file a complaint with the Center, contact Tracy Mason, Privacy Officer, (478) 237-6262 x 01204 215 N. Coleman Dr., Swainsboro, GA 30401. All complaints must be submitted in writing.

You will not be penalized for filing a complaint. **OTHER USES OF MEDICAL INFORMATION.** Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Patient/Parent's/Guardian's Signature

Date Signed

■ 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: _____
(First Name) (Last Name)

Date of examination: _____ Sport(s): _____

Sex assigned at birth: _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional). _____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects). _____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box next to appropriate number)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3

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

HEART HEALTH QUESTIONS ABOUT YOU

(CONTINUED)

	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	☐	☐
10. Have you ever had a seizure?	☐	☐
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)?	☐	☐
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	☐	☐
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	☐	☐

■ 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: ☐ Y ☐ N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	☐	
Eyes, ears, nose, and throat • Pupils equal • Hearing	☐	
Lymph nodes	☐	
Heart ^a • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	☐	
Lungs	☐	
Abdomen	☐	
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis	☐	
Neurological	☐	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	☐	
Back	☐	
Shoulder and arm	☐	
Elbow and forearm	☐	
Wrist, hand, and fingers	☐	
Hip and thigh	☐	
Knee	☐	
Leg and ankle	☐	
Foot and toes	☐	
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test	☐	

^a 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: _____

Principal
Josh White



Treutlen High School
7892 GA Hwy. 297
Soperton, GA 30457
(912) 529-7731



Assistant Principals
Joshua Anderson
Andrew Johnson

Student Drug Testing Procedure

Treutlen County School District has implemented random drug testing of middle and high school students. A safe and effective learning environment is paramount to the success of students. Drug use and abuse are detrimental to the physical, emotional and mental well-being of students. Drug abuse seriously interferes with the academic and athletic performance of students and creates an unhealthy learning environment. The Random Drug Testing Program will have a positive effect on our schools, community and students by serving as a deterrent and offering assistance to students who have drug issues. An important element of the program is the availability of resources for student/parent for any student who may test positive and desire intervention.

Any students participating in privileged activities will be subject to random drug testing at any point during the school year. Privileged activities include but are not limited to any interscholastic activity, such as sports, any interscholastic extracurricular activity, such as band or clubs, and student parking on campus. In short, any student involved in any extracurricular activity will be subject to random drug testing.

When students sign up for these activities, there is a consent that will go home to acknowledge that these test may occur. The testing will pull from numbers randomly assigned to students as they sign up for activities throughout the school year. If testing occurs, it will not occur more than twice a semester and the numbers will be pulled from an Artificial Intelligence generator with no student information provided. Once those numbers are pulled, the Administrator will reach out to the students that have been identified through their number. The testing will occur within the same day.

An independent lab conducts all tests. This test will be administered once there is a consent by the parent. A student's refusal to test is treated as a positive test result. The tests measure the following drugs: marijuana, cocaine, amphetamines, methamphetamines, and opiates. The test results will be returned within 48 hours and differentiate between prescription medications and the drugs listed above. Any positive results are forwarded to the Principal or other designated administrator, who will notify the student and parents of the results and consequences. At that time the parent/guardian and student can discuss the reason for the positive result.

Consequences of positive results range from a twenty five day suspension to permanent suspension from activity or privilege.

- 1st offense - 25 day suspension from privilege
- 2nd offense - 1 year suspension from privilege
- 3rd offense - Permanent suspension from privilege

Treutlen School District Student Drug Testing Consent Form

Participation in school sponsored co- and extra-curricular activities at Treutlen School District is a privilege. Activity Students carry a responsibility to themselves, their fellow students, their families, their school and their community to set the highest possible examples of conduct, which includes avoiding the use or possession of illegal drugs. Chemical use of any kind is incompatible with participation in co- and extra-curricular activities at Treutlen School District.

Treutlen School District has adopted the attached Activity **Student Drug Testing Procedure** and this Student Drug Testing Consent for use by all Activity Students as defined in the Policy. This policy explains in more detail the purpose of drug testing and its implementation. This policy also defines "chemical use" and "illegal drugs".

CONSENT BEFORE PARTICIPATION: Each Activity Student shall be provided with a copy of the Activity Student Drug Testing Policy and this Student Drug Testing Consent, which shall be read, signed and dated by the Activity Student, parent or custodial guardian and coach/sponsor, and returned to the school administration *before* such student shall be eligible to practice or participate in any activities. The Activity Student (and parent/guardian if student is under 18) shall sign this Consent *before* beginning practice or participation in any activities. The consent allows Treutlen Public Schools to obtain a urine sample from each Activity Student: a) if chosen by the random selection basis; and b) at any time based on a reasonable suspicion to be tested for illegal drugs.

Student's Last Name (please print)	First Name	MI
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I have been given, read and understood the "Activity Student Drug Testing Policy" and this "Student Drug Testing Consent". I understand the Treutlen Public Schools enforces the rules applying to the use or possession of illegal drugs as defined in this policy. As a member of a co- and extra-curricular activity, I realize the personal decisions I make daily in regard to the use or possession of illegal drugs may affect my health and well-being, may endanger those around me and may reflect negatively upon myself, my family, my activity, my school and my community. If I choose to violate school policy regarding the use or possession of illegal drugs, I understand I will be subject to discipline and restrictions on my participation as outlined in the Policy. I consent to submit to drug testing in accordance with the Student Activity Drug Testing Policy.

Signature of Student	Date
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We have read and understood the "Activity Student Drug Testing Policy" and this "Student Drug Testing Consent". We desire the student named above to participate in the co- and extra-curricular activities of Treutlen Public Schools. We consent to the implementation and enforcement of the policy, and we agree the student named above will be subject to the policy and will be required to undergo drug testing in order to participate in school activities. We give our consent to drug testing of this student in accordance with the policy and the procedures implementing this policy. We understand the discipline and restrictions on participation that can be enforced against the student for violations as explained in the policy.

Signature of Parent or Guardian	Date
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Signature of Coach/Sponsor	Date
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