



Chattooga High School

Student's Name: _____

DOB: _____

Year in School: Fr So Jr Sr

Parental Consent for Athletic Participation

WARNING: Participation in inter-scholastic athletics includes a risk of injury which may range in severity from minor to long catastrophic injury, including permanent paralysis from the neck down or death. Although serious injuries are not common in supervised athletic programs, it is possible only to minimize, not eliminate the risk. Players have the responsibility to help reduce the chance on injury by obeying all safety rules, reporting all physical equipment daily. By signing this permission from, you, the parent, acknowledge that you have read and understand this warning. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THESE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM.**

I hereby give consent for my child to compete in the Chattooga High School Athletic and to travel with their team to any of its local or out of town events. I also authorize the Certified Athletic Trainer to dispense over the counter medication to my child. I verify that the information on this form is correct and understand that any false information may result in my son/daughter being declared ineligible.

In the case of an emergency or accident involving my child requiring immediate medical or surgical attention, I hereby grant permission to obtain the services of physicians or to transport my child to the hospital if necessary. I also grant permission for my child to be treated by the physicians or Certified Athletic Trainer if I am not present.

Signature of Parent/Guardian

Date

Insurance Information:

In the event that it is needed this information will be provided to EMS and/or medical staff. Please make sure the information is accurate. **PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.**

Company: _____ Name of Insured: _____

Policy #: _____ Group #: _____

Emergency Contact Information:

Primary Contact:

Name: _____ Relationship to Student: _____

Phone#: _____

Alternate Contact:

Name: _____ Relationship to Student: _____

Phone#: _____

Emergency Contact Information:

Primary Contact:

Name: _____
Relationship to Student: _____
Phone#: _____

Alternate Contact:

Name: _____
Relationship to Student: _____
Phone#: _____

Allergies

Please list any **allergies or medical conditions** on the lines provided below along with the type of reaction. Please note that this information is very important. If you do not have any known allergies, please indicate that on the lines below.

Authorization for Medical Treatment

Please READ AND INITIAL EACH item

_____ In the event that my child is injured while participating in interscholastic athletic activities I give consent to FLOYD medical staff to diagnose and treat any injury.

_____ In the event that emergency medical intervention is deemed necessary I give consent to transport my child to higher care.

_____ I give permission for the Certified Athletic Trainer to provide my child with OTC medication if it is deemed necessary.

I further certify that I am the parent, or if no parent is available, the grandparent, or the legal guardian of the child named above and that I not now nor have I ever been adjudicated incompetent in any court of law.

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 2026-2027 school year. This form will be stored with the athletic physical form and other accompanying forms required by the _____ School System.

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

Student Name (Printed)

Student Name (Signed)

Date

Parent Name (Printed)

Parent Name (Signed)

Date

Georgia High School Association

Student/Parent Concussion Awareness Form

SCHOOL: _____

DANGERS OF CONCUSSION

Concussions at all levels of sports have received a great deal of attention and a state law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor “ding” to the head, it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long-term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial – that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GHSA athletics. One copy needs to be returned to the school, and one retained at home.

COMMON SIGNS AND SYMPTOMS OF CONCUSSION

- Headache, dizziness, poor balance, moves clumsily, reduced energy level/tiredness
- Nausea or vomiting
- Blurred vision, sensitivity to light and sounds
- Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments
- Unexplained changes in behavior and personality
- Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

BY-LAW 2.68: GHSA CONCUSSION POLICY: In accordance with Georgia law and national playing rules published by the National Federation of State High School Associations, any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion shall be immediately removed from the practice or contest and shall not return to play until an appropriate health care professional has determined that no concussion has occurred. (NOTE: An appropriate health care professional may include licensed physician (MD/DO) or another licensed individual under the supervision of a licensed physician, such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.

a) No athlete is allowed to return to a game or a practice on the same day that a concussion (a) has been diagnosed, OR (b) cannot be ruled out.

b) Any athlete diagnosed with a concussion shall be cleared medically by an appropriate health care professional prior to resuming participation in any future practice or contest. The formulation of a gradual return to play protocol shall be a part of the medical clearance.

By signing this concussion form, I give _____ High School permission to transfer this concussion form to the other sports that my child may play. I am aware of the dangers of concussion and this signed concussion form will represent myself and my child during the 2026-2027 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

(Revised: 3/26)

■ 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	☐ 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* 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	☐	

* 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: _____



MEDICAL CONSENT – ATHLETIC PARTICIPATION

I give permission to certified athletic trainers (ATCs) employed or contracted with Atrium Health Floyd, physicians, and healthcare providers to treat my child for any school-sponsored athletic injuries or conditions. This includes permission to perform athletic participation evaluations when required; evaluation, treatment, first aid, preventative care and taping, rehabilitation, therapeutic exercise, modalities, emergency care, advanced techniques, and referrals as needed. Athletic trainers work under best practice medical guidelines and in collaboration with physicians and physical therapists to protect student-athlete safety.

EMERGENCY MEDICAL AUTHORIZATION

If my child is injured and immediate medical care is needed, and a parent or guardian cannot be reached in a timely manner, I authorize Atrium Health Floyd staff and/or school officials to arrange emergency medical treatment, including transportation to a hospital if necessary.

AUTHORIZATION TO SHARE LIMITED HEALTH INFORMATION

I authorize athletic trainers and sports medicine staff to share only information related to my child's current athletic injury or condition with treating or consulting physicians, physical therapists involved in care, and school athletic personnel (including the coach and athletic director) when necessary for safe care, participation restrictions, and return-to-play decisions. Medical information unrelated to the current athletic injury will not be shared with school personnel.

AUTHORIZATION FOR EXCHANGE OF MEDICAL INFORMATION (HEALTHCARE PROVIDERS)

I authorize Atrium Health Floyd and any other healthcare providers involved in my child's care to send and receive medical information pertaining to the current athletic injury or medical condition as necessary for coordinated care. This includes evaluation findings, treatment plans, progress notes, and recommendations, as well as any information required to assess participation in sports and ensure continuity of care.

MEDICAL DOCUMENTATION AND PRIVACY

I understand that evaluation and treatment related to my child's athletic injury or condition may be documented in Atrium Health Floyd's electronic medical record (EMR) in accordance with applicable privacy laws. Access to this information is limited to authorized healthcare professionals.

CONSENT DURATION AND REVOCATION

This consent remains valid for as long as the student athlete is enrolled as a student at this school, unless revoked in writing by the parent or legal guardian. Revocation does not affect medical care provided or information released based on this consent prior to the date the revocation is received.

Student-Athlete Signature: _____ Date: _____

Parent / Legal Guardian Signature: _____ Date: _____

Printed Name: _____



Please include a copy of
your insurance card
front and back with this
packet.