ATLANTA PUBLIC SCHOOLS ATHLETICS

Please read and complete each section of this document. Form must be completed before students are cleared to participate.

Part I
PARENT CONSENT FOR ATHLETIC PARTICIPATION AND EMERGENCY MEDICAL TREATMENT

I, ____________________________________________, parent or guardian, hereby give consent for my child or ward, ____________________________________________, to compete in middle school or high school athletics for
Middle/High School. Should at any time I desire said student to refrain from participating, I will notify the athletic director or head coach of said school in writing. I fully understand insurance coverage and limitations. Also, in consideration of my son/daughter's opportunity to participate in interscholastic activities, I hereby consent to emergency medical treatment, hospitalization or other medical treatment as may be necessary for the welfare of the above-named child, by a physician, qualified nurse, and/or hospital, in the event of injury or illness during all periods of time in which the student is away from his/her legal residence as a member of an interscholastic activity team or group, and hereby waive on behalf of myself and the above-named child any liability of The Atlanta Board of Education, any of its agents or employees, arising out of such medical treatment.

WARNING: PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH. PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM.

By signing this form, I acknowledge that I have read and understand this warning and consent for participation and emergency medical treatment.

Parent's or Guardian's Signature ___________________________ Date ___________________________

Part II

PLEASE CHECK ONE OF THE FOLLOWING INSURANCE OPTIONS

☐ OPTION NO. 1: I hereby certify that my child or ward, ____________________________________________, is a member of a group or her private hospital and medical plan and/or Medicaid and is covered by that policy or plan for injuries, which may occur from athletic participation. Coverage there under is provided by ______________________ under Policy No. _______________________. I understand and affirm that, in light of my selection of this Option, the Atlanta Board of Education has relied upon this certification by me in allowing my child or ward to participate in middle/high school athletics. I will notify the Atlanta Board of Education in writing of any changes in coverage within ten (10) days of said change.

☐ OPTION NO. 2: I hereby certify that my child or ward, ____________________________________________, is not a member of a group or other private hospital and medical plan, including Medicaid, and is not covered by any policy or plan for injuries which may occur from athletic participation. I understand that the Atlanta Public School System will make available limited excess medical coverage as per insurance outline/overview for my child or ward in consideration for premium in the amount of $12.00 for Varsity, Jr. Varsity and Middle School Athletics paid by me on behalf of my child or ward. I further understand that no payment will be made for any medical expense incurred after the policy period expires on June 30, 2012, regardless of the date of the child's/ward's injury. All medical expenses incurred must be submitted no later than July 30, 2012. All medical expenses are excess over any other valid insurance including Medicaid. I understand that I am responsible for the filing of any and all medical claims. I have read and understand the benefits and exclusions.

NOTE: THERE CAN BE NO PARTICIPATION IN THE ATHLETIC PROGRAMS OF THE ATLANTA PUBLIC SCHOOLS UNLESS THE STUDENT IS COVERED BY A GROUP PLAN, MEDICAID OR IN THE EVENT OF NO INSURANCE, THE LIMITED EXCESS BENEFIT PLAN MADE AVAILABLE THROUGH THE ATLANTA PUBLIC SCHOOLS.

I understand and affirm my selection of this option.

Parent's or Guardian's Signature ___________________________ Date ___________________________

Part III

STUDENT MEDIA RELEASE FORM

I hereby agree to allow my child, ____________________________________________, to be photographed, videotaped and/or voice recorded and for his/her name, image, likeness and voice to used APS approved photographs, videos, publications, news media and web pages for special projects or publicity aimed at promoting school activities and sound teaching practices.

I am aware that my child may be asked a variety of questions concerning school and school-related activities and programs, and that the contents of the interview may be published or aired publicly. I understand that my child will be under the supervision of a school staff member during the interview or photo session, though not if the photographs or video or voice recordings are part of a general background scene in which my child is not identified.

My child reserves the right to refuse to answer any questions or participate in any discussions that make him/her feel uncomfortable or embarrassed. Additionally, my child and or the supervising school agent reserves the right to terminate the interview, photo or video session at any time if said activities cause embarrassment or discomfort to the child.

I understand that neither APS, nor the news media, has any obligation to air or publish the image, videos, videotape and/or voice of my child. I also understand that neither my child nor I will receive any monetary compensation for the rights granted herein. And I understand that my child's appearance or the use of his/her voice in any publication, photo or televised form does not confer any ownership rights on my child or me.

If by reason of my child's statements and actions in the interview, photos, images, videotape and/or voice recording, or the materials furnished to my child for the same, there is any claim or litigation involving any child by third parties of violation or infringement of their right, I agree to indemnify and hold harmless Atlanta Public Schools, its staff and its licensee, and assignee from liability, loss or expenses arising from such claim or litigation.

Parent's or Guardian's Signature ___________________________ Date ___________________________

2011
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 ____________________________ Date of birth ____________________________

Name ____________________________________________________________

Sex ___________________________________ Age _______ Grade _______ School ________

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 □ Animal Hair □ 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 □ Asthmatic □ Asthma □ 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
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, amyloidosis right ventricular cardiomyopathy, long 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, cast, or staples?
20. Have you ever had a stress fracture?
21. Have you ever been told that you have or have had an x-ray for neck instability or atlantoaxial instability? (Torticollis syndrome or dislocation)
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 (male), your spleen, or any other organ?
30. Do you have spinal or back pain in the spine 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 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

Yes No
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 ______________

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Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ___________________________ Date of birth ___________________________
Name ___________________________ Grade ___________________________ School ___________________________ Sport(s) ___________________________

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Do you regularly use a brace, assistive device, or prosthesis?</td>
<td></td>
</tr>
<tr>
<td>7. Do you use any special brace or assistive device for sports?</td>
<td></td>
</tr>
<tr>
<td>8. Do you have any rash, pressure sores, or any other skin problems?</td>
<td></td>
</tr>
<tr>
<td>9. Do you have a hearing loss? Do you use a hearing aid?</td>
<td></td>
</tr>
<tr>
<td>10. Do you have a visual impairment?</td>
<td></td>
</tr>
<tr>
<td>11. Do you use any special devices for bowel or bladder function?</td>
<td></td>
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<tr>
<td>12. Do you have burning or discomfort when urinating?</td>
<td></td>
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<tr>
<td>13. Have you had autonomic dysreflexia?</td>
<td></td>
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<tr>
<td>14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?</td>
<td></td>
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<tr>
<td>15. Do you have muscle spasticity?</td>
<td></td>
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<tr>
<td>16. Do you have frequent seizures that cannot be controlled by medication?</td>
<td></td>
</tr>
</tbody>
</table>

Explain "yes" answers here ___________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Please indicate if you have ever had any of the following.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atlantoaxial instability</td>
<td></td>
</tr>
<tr>
<td>X-ray evaluation for atlantoaxial instability</td>
<td></td>
</tr>
<tr>
<td>Dislocated joints (more than one)</td>
<td></td>
</tr>
<tr>
<td>Easy bleeding</td>
<td></td>
</tr>
<tr>
<td>Enlarged spleen</td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis or osteopenia</td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bowel</td>
<td></td>
</tr>
<tr>
<td>Difficulty controlling bladder</td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in arms or hands</td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling in legs or feet</td>
<td></td>
</tr>
<tr>
<td>Weakness in arms or hands</td>
<td></td>
</tr>
<tr>
<td>Weakness in legs or feet</td>
<td></td>
</tr>
<tr>
<td>Recent change in coordination</td>
<td></td>
</tr>
<tr>
<td>Recent change in ability to walk</td>
<td></td>
</tr>
<tr>
<td>Spina bifida</td>
<td></td>
</tr>
<tr>
<td>Latex allergy</td>
<td></td>
</tr>
</tbody>
</table>

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 ___________________________

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

<table>
<thead>
<tr>
<th>Weight</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________</td>
<td>__________</td>
</tr>
</tbody>
</table>

Medical

Appearance
- Moisten stigmate, lymphadenopathy; acute exanthem, anorexia, mouth sores

Eyes/nose/throat
- Pupils equal
- Hearing

Lymph nodes

Heart
- Murmurs (systolic ejection, murmur, +/– radiation)
- Location of point of maximal impulse

Pulses

Lungs

Abdomen

Semen/urinary (males only)

Skin
- MSN lesions suggestive of MRSA, lice, candidiasis

Neurology

Musculoskeletal

Neck

Back

Shoulder/arm

Elbow/forearm

Wrist/hand/fingers

Hip/thigh

Knee

Leg/ankle

Foot/toe

Functional
- Duck-walk, single leg hop

*Consider EKG, echocardiogram, and referral to cardiologist for abnormal cardiac history or exam.
*Consider Gill exam if private setting, having third party present is recommended.
*Consider cognitive evaluation or baseline neuropsychometric 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
   ☐ Reasons

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/copy) __________________________________________ 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 ____________________________________________

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