

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 gives 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's/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: BY ITS NATURE, 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, (name) _____ is a member of a group or to 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 (name of Company) _____, 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 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 my child's/ward's injury. All medical expenses incurred must be submitted no later than June 1, 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/or 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 be 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 my child.

I understand that neither APS, nor the news media, has any obligation to air or publish the image, photos, 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 charge by third parties of violation or infringement of their right, I agree to indemnify and hold harmless Atlanta Public Schools, its staff and its licensees, and assigns from liability, loss or expenses arising from such claim or litigation.

Parent's or Guardian's 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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> 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: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> 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 _____

PREPARTICIPATION PHYSICAL EVALUATION THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

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

Explain "yes" answers here

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

| | Yes | No |
|---|------------|-----------|
| Atlantoaxial instability | | |
| X-ray evaluation for atlantoaxial instability | | |
| Dislocated joints (more than one) | | |
| Easy bleeding | | |
| Enlarged spleen | | |
| Hepatitis | | |
| Osteopenia or osteoporosis | | |
| Difficulty controlling bowel | | |
| Difficulty controlling bladder | | |
| Numbness or tingling in arms or hands | | |
| Numbness or tingling in legs or feet | | |
| Weakness in arms or hands | | |
| Weakness in legs or feet | | |
| Recent change in coordination | | |
| Recent change in ability to walk | | |
| Spina bifida | | |
| Latex allergy | | |

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

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

| EXAMINATION | | | |
|---|--------|---|---|
| Height | Weight | <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| BP / (/) | Pulse | Vision R 20/ | L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N |
| MEDICAL | NORMAL | ABNORMAL FINDINGS | |
| Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) | | | |
| Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing | | | |
| Lymph nodes | | | |
| Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) | | | |
| Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses | | | |
| Lungs | | | |
| Abdomen | | | |
| Genitourinary (males only) ^b | | | |
| Skin <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Duck-walk, single leg hop | | | |

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
^bConsider GU exam if in private setting. Having third party present is recommended.
^cConsider 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 _____
