



Dear Parent/Guardian:

Attached is documentation required in order for your child to participate in middle school and high school athletics in Kershaw County School District. Please read this information completely, and feel free to contact the athletics department at your child's school should you have any questions or concerns. All forms must be completed prior to participation in any athletics related activity.

Please fill out the following and provide necessary documentation:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Contact No: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Contact No: \_\_\_\_\_  
In Case of Emergency: \_\_\_\_\_ Contact No: \_\_\_\_\_  
Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Family Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Preferred Hospital: \_\_\_\_\_  
Do you have health insurance? Y / N      Name of Company: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ Insured's Name: \_\_\_\_\_  
Policy # \_\_\_\_\_  
Do you have Medicaid? Y / N      Medicaid Number: \_\_\_\_\_

Kershaw County carries athletic accident insurance on all its athletes, intended to be an "excess" policy designed to pay secondarily to the athlete's primary health insurance. In the event of an injury, while participating as a part of a SCHSL sanctioned sports team representing a KCSD School, the athlete should seek the attention of the sports medicine staff as soon as possible. The head athletic trainer will fill out the top portion of the insurance claim form. The parent/guardian should complete the remainder of the claim form, follow the attached directions, and mail the completed form to the insurance company.

*\*Please note the claim must be filed within 90 days of the injury.*

In consideration of the student named above being permitted to voluntarily participate in the sport, activity, club, and program, I for myself, my child and our heirs, personal representatives, and /or assigns, do hereby release, agree to hold harmless, and waive any claim against, discharge for liability, and promise not to sue the Kershaw County School District, its officers, employees, volunteers, and/or agents for liability from all and all claims including the negligence of the Kershaw County School District, its officers, employees, and agents, with respect to any and all personal injury, accidents, illness, or property loss or property damage arising from, but not limited to the above-named student's participation in the activity.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Kershaw County School District  
Participation Form

Permission to Participate, Assumption the Risk,  
And Secondary Insurance Acknowledgement

As the parent or legal guardian of the above named student-athlete, I/we give my permission for his/her participation in athletic events and physical evaluation (PPE) by a physician, physician's assistant, or nurse practitioner for that participation. I/We understand that the PPE is simply a screening evaluation and not a substitute for regular healthcare. I/We know that the risk of injury/illness to my child comes with participation in sports and during travel to/from activities. I/We have had the opportunity to understand the risk of injury during participation in sports through meetings, written information, or by some other means and give my/our permission to participate in interscholastic athletics. Kershaw County School District carries athletic accident insurance on all students participating in extracurricular activities. This accident insurance benefits provided by the school system will pay only toward those covered expenses in excess of expenses recoverable from other insurance. There are limitations under this insurance coverage. It will not always pay all of the charges incurred for every accident. In the event of injury, while participating as a part of a SCHSL sanctioned sports team representing KCSD, the athlete should seek the attention of their school's Sports Medicine staff as soon as possible. A staff member will fill out the top portion of the insurance claim form. The parent/guardian should complete the remainder of the form, follow the directions, and mail the completed form to the insurance company. Medical care must be initiated within 60 days, and forms must be submitted directly to the Insurance Company by the PARENT within 90 days of the date of injury to be eligible for coverage. KCSD or its schools cannot be held responsible for the financial or other costs associated with injuries sustained while participating in athletics.

Concussion Information

I have received and understood information in some means regarding concussions and brain injury, which has informed me of the nature and risk of concussion and brain injury, including the risks associated with continuing to participate in physical activity after a concussion or brain injury. I understand that any symptom(s) of concussion should be reported to my child's coach immediately, and that my child should not participate in any physical activity, driving of a motor vehicle, or strenuous mental activity until evaluated for concussion and cleared by an appropriate healthcare provider (physician, athletic trainer, physician assistant, or nurse practitioner). If diagnosed with a concussion, I understand that my child must be symptom free, cleared by a licensed physician, and complete a gradual return to play protocol supervised by a qualified medical professional prior to resuming physical activity in accordance with South Carolina State Law. It is highly recommended that the clearing physician be specifically trained in the management of sports related concussion

Release of Medical Information

I/We grant permission to Nurses, Certified Athletic Trainers, Coaches, Physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to all necessary medical information. I/We grant the school's Sports Medicine staff access to medical information concerning my son/ daughter by a physician or their staff. Likewise, the school's Sports Medicine staff may release medical information to Physician's offices, Coaches, Nurses, Administrators, and school/district Faculty/Staff.

Consent for Medical Treatment

I/We give consent for treatment deemed necessary for a condition arising during participation of events, including medical or surgical treatment recommended by a medical doctor. I grant permission to Certified Athletic Trainers and Coaches, as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. Furthermore, I give permission for my child to receive medical care, without explicit parental notification, from the school's Sports Medicine staff and/or Team Physicians if he/she becomes injured while participating in an event.

*By signing below, I attest that the provided information is correct, and that I understand and agree to the statements above regarding Permission to Participate, Assumption of Risk, Secondary Insurance Acknowledgement, Release of Medical Information, Concussion Acknowledgement, and Consent for Medical Treatment. I/We commit to reporting ALL injuries and illnesses to the Sports Medicine staff, especially any symptoms of a possible concussion. Please contact the school's Athletic Director/ Sports Medicine Staff prior to scheduling any appointments for injuries sustained as a result of participation in athletics. I/We also understand that the Sports Medicine staff requires written documentation and clearance from any medical care received prior to returning to activities, even if it is not the result of participation in athletics. When the Sports Medicine staff determines that advanced medical care is required, the athlete must provide written clearance from an appropriate provider, prior to returning to participation. I/we will not condone participation in any activities against medical advice or until the athlete is cleared by an appropriate medical provider (as determined by the school's Sports Medicine staff).*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Preparticipation Physical Evaluation - Physical Form

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_

Examination			
Height:	Weight:		
BP: / ( / )	Pulse:	Vision: R 20/ L 20/	Corrected ___ Yes ___ No

Medical	Normal	Abnormal Findings
<b>Appearance:</b> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse (MVP), and aortic insufficiency)		
<b>Eyes / Ears / Nose / Throat</b> - Pupils equal / Hearing		
<b>Lymph Nodes</b>		
<b>Heart</b> - Murmurs (auscultation standing, auscultation supine, and +/- Valsalva maneuver)		
<b>Lungs</b>		
<b>Abdomen</b>		
<b>Skin</b> - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant Staphylococcus aureus (MRSA), or tinea corporis		
<b>Neurologic</b>		
<b>Musculoskeletal:</b>		
- Neck		
- Back		
- Shoulders/Arm		
- Elbow/Forearm		
- Wrist/Hand/Fingers		
- Hip/Thighs		
- Knees		
- Leg/Ankles		
- Foot/Toes		
- Functional: Double-leg squat test, single leg squat test, and box drop or step drop test		

Consider: electrocardiography (ECG), echocardiography, and referral to cardiologist for abnormal cardiac history or examination findings or a combination of those.

### Preparticipation Physical Evaluation

- 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. If conditions arise after the athlete had 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

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# 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: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

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): \_\_\_\_\_

General Questions		Yes	No	Medical Questions		Yes	No
<small>Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.</small>				<b>16. Do you cough, wheeze, or have difficulty breathing during or after exercise?</b>			
1. Do you have any concerns that you would like to discuss with your provider?				<b>17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?</b>			
2. Has a provider ever denied or restricted your participation in sports for any reason?				<b>18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?</b>			
3. Do you have any ongoing medical issues or recent illness?				<b>19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?</b>			
<b>Heart Health Questions About You</b>				<b>20. Have you ever had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?</b>			
4. Have you ever passed out or nearly passed out DURING or AFTER exercise?				<b>21. Have you ever had numbness, tingling, or weakness in your arms or leg, or been unable to move your arms or legs after being hit or falling?</b>			
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				<b>22. Have you ever become ill while exercising in the heat?</b>			
6. Does your heart ever race, flutter in your chest or skip beats (irregular beats) during exercise?				<b>23. Do you or someone in your family have sickle cell trait or disease?</b>			
7. Has a doctor ever told you that you have any heart problems?				<b>24. Have you ever had or do you have any problems with your eyes or vision?</b>			
8. Has a doctor ever ordered a test for your heart? (for example Electrocardiography (ECG) or echocardiography.				<b>25. Do you worry about your weight?</b>			
9. Do you get lightheaded or feel shorter of breath than your friends during exercise?				<b>26. Are you trying to or has anyone recommended that you gain or lose weight?</b>			
10. Have you ever had a seizure?				<b>27. Are you on a special Diet or do you avoid certain types of foods?</b>			
<b>Health Questions About Your Family</b>				<b>28. Have you ever had an eating disorder?</b>			
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 (including drowning or unexplained car accident)?				<b>Females Only</b>			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?				<b>29. Have you ever had a menstrual period?</b>			
13. Does anyone in your family had a pacemaker or implanted Defibrillator before age 35?				<b>30. How old were you when you had your first menstrual period?</b>			
<b>Bone and Joint Questions</b>				<b>31. When was your most recent menstrual period?</b>			
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a game or practice?				<b>32. How many periods have you had in the past 12 months?</b>			
15. Do you have a bone, muscle, ligament or joint injury that bothers you?				Explain a "Yes" answer here: _____ _____ _____ _____			

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

Date \_\_\_\_\_

# CONCUSSION

## INFORMATION FOR STUDENT-ATHLETES & PARENTS/LEGAL CUSTODIANS

**What is a concussion?** A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

**How do I know if I have a concussion?** There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Headache	Irritability-things bother you more easily	Sleeping more than usual
Taking longer to figure things out	Fuzzy or blurry vision	Sadness	Sleeping less than usual
Difficulty concentrating	Feeling sick to your stomach/queasy	Being more moody	Trouble falling asleep
Difficulty remembering new information	Vomiting/throwing up	Feeling nervous or worried	Feeling tired
	Dizziness	Crying more	
	Balance problems		
	Sensitivity to noise or light		

Table is adapted from the Centers for Disease Control and Prevention (<http://www.cdc.gov/concussion/>)

**What should I do if I think I have a concussion?** If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

**When should I be particularly concerned?** If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/shurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

**What are some of the problems that may affect me after a concussion?** You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur once you have a concussion, you are more likely to have another concussion.

**How do I know when it's ok to return to physical activity and my sport after a concussion?** After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

**You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign your brain has not recovered from the injury.**