



CHEROKEE COUNTY SCHOOL DISTRICT
Athletic Parental Consent, Insurance, Authorization and Waiver and Release Form
2018-19 School Year



Please INITIAL one of the following statements regarding insurance coverage for your student for the current school year, then sign below.

____ My student is adequately and currently covered by accident insurance that will cover injuries sustained while participating in any school authorized activity (including, but not limited to Varsity or JV Football).

Insurance Company	Name of Insured	Policy Number
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____ I have purchased the Benefit Plan provided by CCSD. I understand this is a supplemental policy. (A copy of this Benefit Plan should be attached)

Signature(s) Parent(s)/Guardian(s)	Date
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AUTHORIZATION AND WAIVER

I/We certify that the medical history on this form is complete and accurate. I/We understand that this will serve as the basis for determining that my student may compete in middle/high school athletics within CCSD. I/We also understand this medical evaluation is general in nature and only performed to determine fitness for athletics and is not to take place of regular medical examinations. In case of an emergency or accident on/off school grounds during any school activity or athletic event, which in the opinion of school authorities present requires immediate medical or surgical attention, I/we hereby grant permission to physicians, consulting physicians, certified athletic trainers, emergency medical technicians, and other healthcare providers selected by school authorities to provide medical care and treatment (including hospitalization if deemed necessary) unless I am present and request otherwise or until I later request otherwise.

I/We understand that the terms hereof apply to any injury, illness or other medical problem or emergency that arises as a result of or in connection with any aspect of athletic participation for CCSD, including tryouts, practice, conditioning, meetings, games, and/or travel. I/We also understand that reasonable efforts will be made to contact parent(s) or legal guardian(s) before any serious or involved medical treatment.

I/We understand that per GHSA, a Pre-Participation Physical Evaluation must be performed by a physician to medically screen each student who participates in the athletic program(s) of CCSD. I/We further understand that a basic medical screening (the required physical exam) is general in nature and limited in its scope and does not indicate or assure me that my student is completely free from impairments. If I/we wish for a more detailed physical exam to be performed upon my student, then it is my responsibility to arrange and pay for such an exam. If this more detailed exam is performed, it is my responsibility to notify CCSD and its appropriate employees, of any potential medical problems uncovered by any physical exam given to my student other than the general physical required by the school system for athletic participation.

I/We assume all liability and responsibility for any and all potential or real risks, injuries or even death which may result from Student's participation in inter-scholastic athletics, sports teams/clubs and events. I/We represent and warrant that I/we know of no mental or physical condition that would make it unsafe for Student to participate in inter-scholastic athletics, sports teams/clubs and events. I/We understand, acknowledge and agree that CCSD shall not be liable for any injury/illness suffered by the Student which arises out of and/or is associated with preparing for and/or participating in inter-scholastic athletics, sports teams/clubs and events.

I/We hereby release, discharge, indemnify, and agree to hold harmless CCSD, Members of the CCSD Board of Education, its past, present and future officers, attorneys, agents, employees, predecessors and successors in interest, and assigns, hereinafter "CCSD Releasees", from any and all liability arising out of or in connection with Student's participation in inter-scholastic athletics, sports team/clubs and events. For purpose of this Release, liability means all claims, demands, losses, causes of action, suits, or judgements of any kind that Student or Student's parents, guardians, heirs, executors, administrators, and assigns have or may have against the CCSD Releasees because of Student's personal, physical, or emotional injury, accident, illness or death, or because of any loss of or damage to property that occurs to Student or his or her property including Student's participation in inter-scholastic athletics, sports teams/clubs and events due to acts of passive or active negligence by CCSD Releasees other than actions involving fraud or actual malice.

By signing below, I/we acknowledge that I/we have carefully read this voluntary Waiver and understand the potential dangers incident to engaging in inter-scholastic athletics, sports teams/clubs and events, and are fully aware of the legal consequences of this agreement.

Signature(s) Parent(s)/Guardian(s)	Date
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Signature of Student	Date
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THIS ACKNOWLEDGEMENT OF AUTHORIZATION AND WAIVER SHALL REMAIN IN EFFECT UNTIL REVOKED IN WRITING.

Signature(s) Parent(s)/Guardian(s)	Date
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STUDENT TRANSPORTATION RELEASE AND CONSENT FORM

While CCSD provides transportation through the utilization of the District bus fleet for many extracurricular events, in some cases school sponsored transportation is not available. In those instances, it is necessary for the parent/guardian to make arrangements for transportation. CCSD discourages students from riding with other students to and from extracurricular events.

I/We, _____, parent/guardian of _____(student) hereby give my/our permission for my student to provide his/her own transportation to/from extracurricular events, and I/we, parent/guardian of the student listed above, hereby give my permission for my/our student to ride with another parent.

I/We hereby consent on behalf of the student named to participate in school-sponsored trips. I/We understand that transportation may or may not be provided by CCSD. In the event transportation is not provided by CCSD, transportation will be the student's and parent(s)/guardian(s) responsibility.

Signature(s) Parent(s)/Guardian(s)

Date

RELEASE OF INFORMATION TO MEDIA AND COLLEGES

I/We hereby authorize the release of any and all information relating to the athletic participation of the above-named student to the media and to all college recruiters, including any medical information concerning injury or illness, any biographical information, and any other information related to the athletic participation, including ability, attitude and conduct.

Signature(s) Parent(s)/Guardian(s)

Date

GUIDELINES FOR OUTDOOR EXTRACURRICULAR ACTIVITIES DURING EXTREME HOT AND HUMID WEATHER

I/We hereby verify that I/we have received and reviewed the CCSD Guidelines for Outdoor Extracurricular Activities During Extreme Hot and Humid Weather.

Signature(s) Parent(s)/Guardian(s)

Date

STUDENT ATHLETE CONCUSSION AWARENESS, DIAGNOSIS AND MANAGEMENT PROGRAM

(GHSAA 02.18)

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 GHSAA athletics. One copy needs to be returned to the school, and one retained at home.

COMMONS 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: GHSAA 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.



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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/we 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 2018-2019 school year. This form will be stored with the athletic physical form and other accompanying forms required by CCSD.

I/We have read the information concerning usage of the Immediate Post-Concussion Assessment and Cognitive Test (ImPACT™) and understand its contents. I/We have been given an opportunity to ask questions and all have been answered to my satisfaction. I/We understand that participation in the ImPACT™ concussion baseline testing is highly recommended but not required for athletes in Cherokee County schools. I/We also understand that the ImPACT™ testing is merely a tool to assist Medical Professionals in the diagnosis and subsequent treatment of potentially serious injuries, the ImPACT™ testing IS NOT a substitute for treatment by a Medical Professional.

I/We acknowledge that if my/our child is suspected of receiving a concussion causing injury, my/our child WILL NOT be allowed to participate in athletics until cleared by an appropriate health care provider. (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.)

Please INITIAL one of the choices below, sign and date:

_____ YES, I give permission for my child, _____, to participate in baseline training with the ImPACT™ program.

_____ NO, I do not give permission for my child, _____, to participate in baseline testing.

Signature(s) Parent(s)/Guardian(s)

Date

Signature of Student

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 • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart ^a • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only) ^b		
Skin • 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 • 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 _____
