



ATHLETIC PARTICIPATION, INSURANCE, AND CONSENT FORM

*Parents and students signature needed in four places

PLEASE PRINT

Name (Last) (First) (Middle) Male Female

Address (Street) (City) (Zip)

The student is domiciled at the above address located in High School District. (School must be notified if student moves from the above address)

Have you attended this Cobb County school for at least one full school year? Yes No

You live with (Name of Parent/Parents/Guardian)

Date of Birth Telephone (Home) (Work)

Date entered 9th grade Your grade level for the 2011-2012 school year

PARENTAL CONSENT FOR ATHLETIC PARTICIPATION

WARNING: BY ITS NATURE, PARTICIPATION IN INTER-SCHOLASTIC ATHLETICS AND INTRA-SCHOLASTIC SPORTS CLUBS INCLUDES A RISK OR INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG TERM CATASTROPHIC, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH. It is not possible to eliminate this risk.

Participants have the responsibility to help reduce the chance of injury. PARTICIPANTS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES OR CLUB SUPERVISORS FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR EQUIPMENT DAILY.

By signing this permission form, you acknowledge that you have read and understand this warning. PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM.

In the event transportation related to the student's athletic/sports activities is not provided by the Cobb County School District or the student does not take advantage of the district-provided transportation, transportation will be the student's or the parents'/guardians' responsibility.

I (We) hereby give consent for (student's name) to:

(1) Compete in athletics at High School of the Cobb County School District in the following Georgia High School Association approved sports:

(2) Participate in the sports club at High School of the Cobb County School District. Please note that sports clubs that are not under the direct supervision and control of the District and local school are not officially sanctioned sports clubs. Parents should carefully inquire as to the leadership and rules of these outside community sporting groups.

(3) And to accompany any school team or sports club of which the student is a member on any of its local or out-of-town trips.

I hereby verify that the information on both sides of this form is correct and understand that any false information may result in my son/daughter being declared ineligible. I understand that students found illegally enrolled out of their school attendance zone could be ruled ineligible for GHSA competition.

Parents should contact Head Coach for information regarding injuries to their son/daughter.

This acknowledgement of risk and consent to allow participation shall remain in effect until revoked in writing.

Signature and Date lines for Parent(s) or Guardian(s), Student Athlete, and Date.

COBB COUNTY SCHOOL DISTRICT PERMISSION TO PARTICIPATE IN ATHLETIC TEAM ONE-DAY SCHOOL-SPONSORED TRIPS

CONSENT

I hereby consent for _____ (student's name) to participate in school-sponsored trips, excluding overnight trips, associated with inter-scholastic athletic and/or intra-scholastic sport club competitions. I understand that transportation may or may not be provided by the Cobb County School District. IN THE EVENT TRANSPORTATION IS NOT PROVIDED BY THE COBB COUNTY SCHOOL DISTRICT, TRANSPORTATION WILL BE THE STUDENT'S OR THE PARENTS'/GUARDIANS' RESPONSIBILITY.

If any emergency medical procedures or treatment are required by the student during the trip, I consent to the trip supervisor(s) taking, arranging for, and consenting to the procedures or treatment in his/her discretion.

I release and waive, and further agree to indemnify, hold harmless or reimburse the Cobb County School District, the Board of Education, its successors and assigns, its members, agents, employees and representatives thereof, as well as trip supervisors, from and against, any claim which I, any other parent or guardian, the student, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, from any losses, damages or injuries arising out of, during, or in connection with the student's participation in the activity, any trip or transportation associated with the activity, or the rendering or emergency medical procedures or treatment, if any.

_____	_____
*Signature(s) of Parent(s) or Guardian(s)	Date
_____	_____
*Signature of Student Athlete	Date

INSURANCE INFORMATION

Please INITIAL one of the following statements regarding insurance coverage for your son/daughter for the 2011-2012 school year, then sign below:

____ My son/daughter is adequately and currently covered by accident insurance that will cover injuries sustained while participating in inter-scholastic Athletics (including, but not limited to, Varsity and Junior Varsity Football), and intra-scholastic clubs and activities.

Company Providing Insurance: _____

Name of Insured: _____

Policy Number: _____

____ I wish to purchase the Benefit Plan provided by the Cobb County School System. (A copy of this Benefit Plan should be stapled to this form)

_____	_____
*Signature(s) of Parent(s) or Guardian(s)	Date
_____	_____
*Signature of Student Athlete	Date

AUTHORIZATION

I understand that per The Georgia High School Association a **Pre-participation Physical Evaluation** must be performed by a physician to medically screen each student who participates in the athletic programs of the Cobb County School District. I 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 child is completely free from impairments. If I wish for a more detailed physical exam to be performed upon my child/ward 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 the Cobb County School District, and its appropriate employees, of any potential medical problems uncovered by any physical exam given to my child/ward other than the general physical required by the school system for athletic participation. I agree to fully waive any and all claims of whatever nature, fully and finally, now and forever, for my child/ward, for myself, my estate, my heirs, my administrators, my executors, my assignees, my agents, my successors, and for all members of my family, and to indemnify, release, defend, exonerate, discharge and hold harmless the Cobb County School District, their schools, their trustees, officers, Board members, Board of Education, employees, agents, coaches, athletic trainers, physicians, and any other practitioner of the healing arts (an "Indemnified Party") from any and all liability, personal or property damages, claims, causes of action or demands brought against the Cobb County School District or indemnified party arising out of any injuries to my child/ward or to his or her property or losses of any kind which may result from or in connection with his or her participation in any activity related to the athletic programs provided by the Cobb County School District.

My signature below attests that I have read, understand and concur with the information on this form, and that I give consent for my child to participate in the athletic programs as stated above.

_____	_____	_____
*Signature(s) of Parent(s) or Guardian(s)	Date	Relation to Student
_____	_____	_____
*Signature of Student Athlete	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 _____
