

DEKALB COUNTY ATHLETIC PARTICIPATION CONSENT FORM

(Physicals must be on or after April 1, for the next school year) Three parental signatures required. All information must be provided.

PRINT

NAME: _____ Male _____ Female _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (Zip)

Student lives with: _____ Relationship: _____
(indicate parents, mother only, father only, aunt, brother etc.)

Telephone: Home _____ Work _____ Cell _____

This information is for the school year 2____ - 2____. Your grade level will be _____ (7, 8, 9, 10, 11, 12)

PARENTAL CONSENT FOR ATHLETIC PARTICIPATION

By its nature, participation in inter-scholastic athletics and intra-scholastic sports clubs includes a risk of injury which may range in severity from minor to long term catastrophic, including permanent paralysis or death. Although serious injuries are not common in supervised athletic programs or athletic clubs, it is possible only to minimize, not 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.

I (We) hereby give consent for _____ to:

(Print full name)

- 1) Compete in athletics in the DeKalb County School District in the following Georgia High School Association approved Sport(s)
(Please circle each sport you approve)

Baseball	Basketball	Golf	Volleyball	Swimming & Diving	Lacrosse
Gymnastics	Cross Country	Football	Softball	Wrestling	
Tennis	Rifle Team	Soccer	Track & Field	Cheerleading	

- 2) 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 excluding over-night trips. I understand that transportation may or may not be provided by the DeKalb County School District. (In the event transportation is not provided by the School District, transportation will be the student's responsibility.)
- 3) I release and waive, and farther agree to indemnify, hold harmless or reimburse the DeKalb 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, any sibling, 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 associated with the activity, or the rendering of emergency medical procedures or treatment if any.
- 4) I have insurance for coverage of my son/ daughter in the form indicated below. (Please initial by the type of insurance coverage you have. (You must provide a copy of the insurance card or policy benefits as indicated.)

_____ 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 inter-scholastic clubs and activities. (Attach copy of card)

Insurance Company Name: _____
Name of Insured: _____
Policy number: _____

_____ I have purchased the Benefit Plan provided by the DeKalb County School System. (attach a signed copy of benefit plan)

- 5) I hereby verify that the information on this form is correct and understand that any false information may result in my son/ daughter being declared ineligible.
(Students found illegally enrolled out of their school attendance zone could be ruled ineligible for GHSA competition for one full year.

By signing this permission form, you acknowledge that you have read and understand the risks of participation and agree to the above terms. This acknowledgement of risk and consent to allow participation shall remain in effect until revoked in writing. (Parents or students who do not wish to accept any of these terms or risks should not sign and participation will be denied.)

_____	DATE _____
SIGNATURE(S) PARENT(S) OR GUARDIAN(S)	
_____	DATE _____
SIGNATURE OF STUDENT-ATHLETE	

STUDENT/PARENT CONCUSSION AWARENESS FORM

SCHOOL: _____

SOUTHWEST DECATS HS #576

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

COMMON 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
- Foggiess 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: GHSA 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.
- 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.
- c) It is mandatory that every coach in each GHSA sport participate in a free, online course on concussion management prepared by the NFHS and available at www.nfhslearn.com at least every two years – beginning with the 2013-2014 school year.
- d) Each school will be responsible for monitoring the participation of its coaches in the concussion management course, and shall keep a record of those who participate.

I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.

SIGNED: _____

(Student)

(Parent or Guardian)

DATE: _____



Southwest DeKalb High School Athletic

Release Form

Southwest DeKalb High School goal is to guarantee that all *student-athletes* have equal access to all colleges and universities. In order to reduce delays and ensure all forms are submitted in a timely manner the Athletic Department is requesting parental consent to release *transcripts, ACT and/or SAT test scores* to all perspective colleges and universities.

_____ I hereby give Southwest DeKalb Athletic Department permission to the release transcripts, ACT and/or SAT test scores to all perspective colleges and universities.

_____ I hereby do not give Southwest DeKalb Athletic Department permission to the release transcripts, ACT and/or SAT test scores to all perspective colleges and universities.

Reminder

*Student-athletes must register with NCAA CLEARINGHOUSE to accept an official college campus visit.

*ACT and SAT scores must be sent directly from College Board and ACT

Student signature

Parent Signature

Date

(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.)

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.

[illegible]

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* <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) ^a			
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 			

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^aConsider 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