PARENTAL CONSENT
FOR SPORTS PARTICIPATION

I hereby give my consent for the below mentioned student to represent his/her school in athletic activities indicated above. I consent for the student to undergo the pre-participation medical examination by the physicians and medical assistants recommended by The Westfield School, and agree to abide with their recommendations regarding participation in these events. I also give my consent for the student to accompany the school team on local or out of town trips. I also give my consent for the school personnel to call for assistance and/or take my child to a doctor/emergency room if treatment appears to be needed.

By signing this form, the parents understand that the risk of injury is assumed by the student and parents. However, in the event of injury, certified athletic trainers, physicians, physical therapist, nurses, or others trained in rendering of first aid are available as volunteers or otherwise, and render first aid to any student injured during the course of any such activities or travel, then parents do hereby release and forever discharge such persons as The Westfield School form any liability arising out of any first aid or immediate treatment of injuries.

Student Name: _____

Insurance Company: _____

Policy Number: _____

Group Number: _____

Parent/Guardian Signature: _____

Date: _____

PARENTAL CONSENT

The undersigned grants OrthoGeorgia and its employees and school system approved healthcare providers parental consent for (name of student)_____(date of birth)_____sports physical, assessment, and treatment of any sports injuries he/she may suffer during the _____ school year.

MEDICAL RELEASE

I give permission for the school official, chaperon or representative of OrthoGeorgia involved in the activity with my child to seek medical aid, render first aid if such attention is necessary in the sole discretion of said person involved. In case of emergency, and when I cannot be immediately reached by telephone or otherwise, I give permission to the physician selected by school officials to hospitalize, secure proper treatment, order injections, anesthesia or surgery for my child.

ACKNOWLEDGMENT OF RISK

Both the student and the parent/guardian should read this statement carefully. You should be aware that playing or practicing to play or helping to play or helping with or participating in any manner in any sport can be a dangerous activity involving risks of injury. The dangers and risks of playing, practicing to play, helping or participating in sports include but are not limited to death, serious neck, head and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, and ligaments, tendons and other aspects of Musculoskeletal system and serious impairment to other aspects of the body, general health and well-being. Because of the dangers of participating in sports, the student should recognize the importance of following coaches' instructions regarding playing techniques, training and other team rules and obey such instruction.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE ABOVE.

_____ _____

Parent/Guardian Date

Athlete Emergency Information

(Please print except for signatures) **School** _____

Student _____ Year _____ Date of Birth _____
Parent/Guardian (father) _____ (mother) _____
Home phone _____ Work/cell phone _____
Home phone _____ Work/cell phone _____

Athlete's home address _____
City _____ Zip Code _____ Lives with: (mother) (father) (other) _____
(circle)

PRIVATE (PRIMARY) INSURANCE

Ins. Co. Name _____ Pre-authorization phone # _____
Insurance Company Address _____ City _____ State _____ Zip Code _____
Name of insured _____
Contract/Policy # _____ Group # _____ Other # _____
My son/daughter is covered by the above insurance policy: Yes: ____ No: ____ Effective date: _____

Known Allergies (drug, food, insect, etc.) _____
Special Medical Problems _____
Medications (inhaler, insulin, etc.) _____

The athletic trainer or coach may provide the following over the counter medicines to my child as necessary: antacid, Tylenol (acetaminophen), Advil/Motrin (ibuprofen), Aleve: YES: _____ NO: _____
(Initial)

Parent Guardian Consent to Treatment of Student Athletes

I, _____, the undersigned parent/guardian of _____
(Parent/Guardian) (Name of student)
a minor, do hereby authorize the Athletic Trainer or school representative on my behalf to consent to any medical treatment deemed necessary by any licensed physician/surgeon in the event of illness or injury to the above named minor.

This consent to treat is intended to cover any illness or injury sustained while participating in any school athletic competition or practice, on or off campus, and while traveling to and from the event.

If, in the judgment of any representative of the school, the above named student needs immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school, OrthoGeorgia Healthcare Resources, and any school representative from any claim by any person whomsoever on account of such care and treatment of said student. I hereby authorize any hospital, which has provided treatment to the above named student to surrender custody of that student to the athletic trainer or school representative upon completion of treatment.

_____
Parent/Guardian Signature Date

Concussions

What you need to know

What is the law?

Schools: House Bill 284, the Return to Play Act of 2013, requires all public and private schools to create a concussion policy that, at a minimum, includes these standards:

- Prior to the beginning of each athletic season, an information sheet that informs parents or legal guardians of the risk of concussions must be provided.
- If a youth athlete (ages 7 to 18) participating in a youth athletic activity exhibits signs or symptoms of a concussion, he must be removed from play and evaluated by a healthcare provider.
- Before a youth athlete can return to play, he must be cleared by a healthcare provider trained in the management of concussions.

Recreational Leagues: HB 284 requires recreational leagues to provide an information sheet on the risks of concussion at the time of registration to all youth athletes' (ages 7 to 18) parents or legal guardians.

What is a concussion?

It is a type of brain injury caused by trauma. It can be caused by a hard bump on or blow to or around the head, which causes the brain to move quickly inside the head. You do not have to lose consciousness to have a concussion. If a concussion is not properly treated, it can make symptoms last longer and delay recovery. A second head trauma before recovery could lead to more serious injuries.

What are the signs and symptoms?

There are many signs and symptoms linked with concussion. Your child may not have any symptoms until a few days after the injury. Signs are conditions observed by other people and symptoms are feelings reported by the athlete.

Signs observed by others:

- Appears dazed or stunned
- Forgets plays
- Is unsure of game or opponent
- Moves clumsily
- Answers questions slowly
- Shows behavior or personality changes

Symptoms reported by athlete:

- Headache
- Nausea
- Dizziness
- Fuzzy vision
- Feeling foggy
- Concentration problems

What should you do if you suspect a concussion?*

- Do not let your child play with a head injury.
- Check on your child often after the injury for new or worsening signs or symptoms. If the symptoms are getting worse, take him to the nearest Emergency Department.
- Take your child to the doctor for any symptom of a concussion.
- Do not give your child pain medications without talking to your child's doctor.
- Your child should stop all athletic activity until his doctor says it is OK. Your child must stay out of play until he is cleared by a licensed healthcare provider.
- Educate your child on concussions and why he cannot play until the symptoms are gone. Your child will need a gradual return to school and activities.
- Tell your child's coaches, school nurses and teachers if he has a concussion.

*In case of an urgent concern or emergency, call 911 or go to the nearest emergency department right away.

Warning signs

Call your child's doctor right away if he has:

- New signs that his doctor does not know about
- Existing signs that get worse
- Headaches that get worse
- A seizure
- Neck pain
- Tiredness or is hard to wake
- Continued vomiting
- Weakness in the arms or legs
- Trouble knowing people or places
- Slurred speech
- Loss of consciousness
- Blood or fluid coming from nose or ear
- Large bump or bruise on scalp, especially in infant younger than 12 months

Where can I find more information?

Visit www.choa.org/concussion for a full list of signs and symptoms and return to school and activities guidelines, educational videos and general concussion information.

This is general information and not specific medical advice. Always consult with a doctor or healthcare provider if you have questions or concerns about the health of a child. This piece was created by the concussion team at Children's Healthcare of Atlanta. Provided to you by OrthoGeorgia Sports Medicine.

It is the policy of OrthoGeorgia Sports Medicine that athletes cannot practice or compete in activities until this form is signed and returned. By signing this form, you acknowledge that you have received the fact sheet on concussions.

Athlete's Printed Name_____ **Athlete's Signature**_____ **Date**_____

Athlete's Parent/Guardian Signature_____ **Date**_____

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: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

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).

Patient Health Questionnaire Version 4 (PHQ-4)

*Over the last 2 weeks, how often have you been bothered by any of the following problems? (**check box next to appropriate number**)*

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	☐0	☐1	☐2	☐3
Not being able to stop or control worrying	☐0	☐1	☐2	☐3
Little interest or pleasure in doing things	☐0	☐1	☐2	☐3
Feeling down, depressed, or hopeless	☐0	☐1	☐2	☐3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?	☐	☐
2. Has a provider ever denied or restricted your participation in sports for any reason?	☐	☐
3. Do you have any ongoing medical issues or recent illness?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?	☐	☐
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	☐	☐
7. Has a doctor ever told you that you have any heart problems?	☐	☐
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	☐	☐

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	☐	☐
10. Have you ever had a seizure?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	☐	☐
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	☐	☐
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	☐	☐

BONE AND JOINT QUESTIONS	Yes	No
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 practice or game?	☐	☐
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	☐	☐

MEDICAL QUESTIONS	Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐	☐
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	☐	☐
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?	☐	☐
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	☐	☐
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	☐	☐
22. Have you ever become ill while exercising in the heat?	☐	☐
23. Do you or does someone in your family have sickle cell trait or disease?	☐	☐
24. Have you ever had or do you have any problems with your eyes or vision?	☐	☐

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?	☐	☐
26. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
27. Are you on a special diet or do you avoid certain types of foods or food groups?	☐	☐
28. Have you ever had an eating disorder?	☐	☐
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?	☐	☐
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers 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: _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. 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, e-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-enhancing 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?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	☐	
Eyes, ears, nose, and throat • Pupils equal • Hearing	☐	
Lymph nodes	☐	
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	☐	
Lungs	☐	
Abdomen	☐	
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis	☐	
Neurological	☐	
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck	☐	
Back	☐	
Shoulder and arm	☐	
Elbow and forearm	☐	
Wrist, hand, and fingers	☐	
Hip and thigh	☐	
Knee	☐	
Leg and ankle	☐	
Foot and toes	☐	
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test	☐	

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

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ 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. A copy of the physical examination findings are 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 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

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____