



# 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 <ul style="list-style-type: none"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</li> </ul>		
Eyes/ears/nose/throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>		
Lymph nodes		
Heart* <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, supine, +/- Valsalva)</li> <li>Location of point of maximal impulse (PMI)</li> </ul>		
Pulses <ul style="list-style-type: none"> <li>Simultaneous femoral and radial pulses</li> </ul>		
Lungs		
Abdomen		
Genitourinary (males only) <sup>b</sup>		
Skin <ul style="list-style-type: none"> <li>HSV, lesions suggestive of MRSA, tinea corporis</li> </ul>		
Neurologic <sup>c</sup>		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional <ul style="list-style-type: none"> <li>Duck-walk, single leg hop</li> </ul>		

\*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.  
<sup>b</sup>Consider GU exam if in private setting. Having third party present is recommended.  
<sup>c</sup>Consider 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 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**STUDENT TRANSPORTATION RELEASE AND CONSENT FORM**

While the Cherokee County School District 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. The Cherokee County School District strongly discourages students from riding with other students to and from extracurricular events.

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

**CONSENT AND RELEASE**

I hereby consent on behalf of the student named above to participate in school-sponsored trips. I understand that transportation may or may not be provided by the Cherokee County School District. In the event transportation is not provided by the Cherokee County School District, transportation will be the student's and parent's/guardian's responsibility. If any emergency medical procedure or treatments are required by the student during the trip, I consent to the trip's supervisor taking, arranging for or consenting to the procedures or treatment in his or her discretion. I further release and waive and further agree to indemnify and hold harmless and reimburse the Cherokee County School District, the Board of Education, its successors and assigns, its members, agents, employees, and representatives thereof, as well as the trip supervisor from and against any claim which I, any other person, firm, corporation, or entity 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 or emergency medical procedures or treatment, if any.

\_\_\_\_\_  
Signature(s) of Parent(s) or Guardian(s)

\_\_\_\_\_  
Date

**RELEASE OF INFORMATION TO MEDIA AND COLLEGES**

I 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 of Student

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**GUIDELINES FOR OUTDOOR EXTRACURRICULAR ACTIVITIES DURING EXTREME HOT AND HUMID WEATHER**

I hereby verify that I have received and reviewed the Cherokee County School District Guidelines for Outdoor Extracurricular Activities During Extreme Hot and Humid Weather.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**STUDENT ATHLETE CONCUSSION DIAGNOSIS AND MANAGEMENT PROGRAM**

I have read the information concerning usage of the Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT™) and understand its contents. I have been given an opportunity to ask questions and all have been answered to my satisfaction. I understand that participation in the ImPACT™ concussion baseline testing is highly recommended but not required for athletes in Cherokee County schools. I 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 acknowledge that if my child is suspected of receiving a concussion causing injury, my child WILL NOT be allowed to participate in athletics until cleared by a medical doctor.

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

\_\_\_\_\_ YES, I give permission for my child, \_\_\_\_\_, to participate in baseline testing with the ImPACT™ program.

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

\_\_\_\_\_  
Signature(s) of Parent(s) or Guardian(s)

\_\_\_\_\_  
Date

_____ LAST NAME (Please Print)	_____ FIRST NAME (Please Print)
_____ STUDENT ID NUMBER	_____ SCHOOL YEAR

## STUDENT/PARENT CONCUSSION AWARENESS/ImPACT™ CONSENT FORM

I have received and reviewed the CCSD Student Athlete Concussion Diagnosis and Management Program packet. I understand its contents, which outline the dangers of concussion and signs and symptoms that are associated with concussion injuries. I have been given an opportunity to ask questions and all questions have been answered to my satisfaction. I understand that participation in the ImPACT™ concussion baseline testing is highly recommended but not required for athletes in Cherokee County schools.

I 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 **acknowledge that if my child is suspected of receiving a concussion causing injury, my child WILL NOT be allowed to participate in athletics until cleared by a medical doctor.**

**Please INITIAL one of the lines below:**

\_\_\_\_\_ YES, I give permission for my child, named above, to participate in baseline testing with the ImPACT™ program.

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

**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 (MC/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 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](http://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.

**Please complete the information below, sign, date and return to the coach or athletic trainer for your child's team:**

PARENT NAME (Please Print)	PARENT SIGNATURE	DATE
STUDENT NAME (Please Print)	STUDENT SIGNATURE	DATE
PHONE NUMBER	EMAIL	

## ETOWAH HIGH SCHOOL ATHLETIC CODE OF CONDUCT

As a member of an Etowah team your attitude, effort and conduct will be held to a higher standard than that of a non-participant. Remember your actions on and off the field reflect on you, your parents, your school and community.

### Proper Conduct and Good Sportsmanship

- Treat others as you know they should be treated, and as you wish them to treat you
- Regard the rules of your game as agreements, both in spirit or letter you should not evade or break
- Treat officials and opponents with respect
- Be gracious in victory and defeat
- Be as cooperative as you are competitive
- Be a good role model on and off the field. Do not participate in illegal behavior nor tolerate those who do

### Guidelines for Players

- Players shall at all times represent themselves, their parents, and school with honor, proper conduct, and good sportsmanship
- They shall confine the competitiveness of the game to the field
- They shall comply fully with the rulings of the officials. In no way, either by voice, action, or gesture shall they demonstrate their dissatisfaction with a decision made
- Players will not deface property or remove equipment of any kind from their own school or another school

### Substance Abuse and Arrest Policy

- No student athlete will be permitted to use or possess tobacco (smoke, chew, or snuff), steroids, alcohol, or illicit drugs on or off school grounds
- No student athlete may knowingly be in the presence of those who are in possession of, using, transmitting, or under the influence of any narcotic drug, hallucinogenic drug, amphetamine, barbiturate, marijuana, alcoholic beverage, or intoxicant of any kind on or off campus
- Any arrest or conviction by authorities may cause disciplinary action by the school in relation to participation or membership on the athletic team(s)
- **Action may be taken against a student athlete when the student is seen using or in the presence of others that are using or under the influence of alcohol, illicit drugs, or illegal activities. The student must have been seen by an employee of the Cherokee County Board of Education, law enforcement agent, or reported by the student's parent(s), guardian, or participant (himself/herself).**

Depending on the nature and severity of the violation of the Code of Ethics and Conduct the athlete may be suspended from participation. The second offense will result in a minimum of one calendar year of non-participation. The third offense will result in the student not being eligible to participate in any athletic teams or extracurricular activities at Etowah for the remainder of his/her tenure.

### Guidelines for Spectators

- Be courteous toward opposing players, coaches, and students, there are guests at our school
- Maintain composure and positive personal decorum throughout the contest
- Show respect for the property of the school in which the contest occurs
- Show respect for the officials of the game and those charged with enforcing the policies and procedures
- Create an environment that allows participants to perform without any distractions (let the coaches coach)
- Allow opposing cheerleaders to complete their cheers and show courtesy toward them
- Harassment of any player, coach, spectator, or official will not be tolerated
- Throwing of any object, profanity, or other unsafe conditions will result in removal from the game and possible denial of admission in the future
- Children must be accompanied by an adult of order sibling of high school age
- Parent must supervise their children at all times: they cannot play or run around the facility. (They need to watch the contest with their parents) This is for the safety of all concerned.

---

Parents signature

Printed Name

Date

---

Athlete's signature

Printed Name

Date

A copy of this signed form must be on file in the Athletic Director's Office prior to game participation.