GEORGIA
HIGH SCHOOL
ASSOCIATION

2024/2025 PPE FORMS
PHYSICAL EVALUATION FORMS

GLYNN COUNTY ATHLETICS

STUDENT NAME: _____

CURRENT GRADE LEVEL: _____

CURRENT SCHOOL: _____

Glynn County School System Athletic Department
Athletic Insurance & Consent Form
Please Complete in Blue or Black Ink

Student Name: _____ Age: _____ School Year: 20___ to 20___
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Student Cell: _____

Part 2-Emergency Contact/Medical Information

Parent Name: _____ Cell Phone: _____
Emergency Contact: _____ Phone: _____
Family Physician: _____ Phone: _____
Allergies: _____
Medical Conditions: _____

It is important for you to understand that medical bills related to an athletic injury are the responsibility of the parents. Occasionally, student athletes are injured during practice or games and the school needs to ascertain that the parents have medical insurance in order to cover expenses if an injury occurs. Please check one of the following and complete the information related to your child's insurance coverage.

EVERY ATHLETE MUST HAVE INSURANCE TO PARTICIPATE. (PLEASE INITIAL ONE OF THE STATEMENTS BELOW)

_____ **I have** personal insurance for my child.
Medical Insurance Company: _____ Policy #: _____
Medical Insurance Phone Number: _____
_____ *I wish to purchase athletic insurance for my child.
*Contact Gene Weber Insurance Agency at 321-637-0035 or provider of your choice.

Part 3-Release Statement

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 Glynn County School System. 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 Glynn County School System, and its appropriate employees 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, discharge and hold harmless the Glynn County School System,
Glynn County 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 Glynn County School System 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 Glynn County School System .

I also hereby give permission for my son/daughter to undergo medical treatment for any injury or illness he/she might sustain or acquire while engaged in interscholastic atheltics in the Glynn County School System. I understand that the athletic trainer will perform only those procedures which are within his training, credentials, and scope of professional practice to prevent , care for, and rehabilitate. In the event that more serious medical procedures are required, such as surgery or other invasive procedures, I understand that attempts will be made to contact me for consent. I understand that if my child suffers a potentialy life threatening injury or illness , and in the event I am unable to be contaacted within a resonable period of time, I authorize any duly licensed medical practitioner to perform such procedures as he/she may medically deem necessary to alleviate the problem.

HAVING AND GIVE PERMISSION FOR MY CHILD TO PARTICIPATE IN ATHLETICS. UNDERSTOOD THIS AGREEMENT, I FREELY SIGN THIS PERMISSION FORM TO PROVIDE MEDICAL TREATMENT

Parents/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: _____ (First Name) _____ (Last Name) Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth: _____

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.)

(First Name)

(Last Name)

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?	☐	☐

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: _____

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2023 This form has been modified for use by the GHSA

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____
(First Name) (Last Name)

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[o] • 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	☐	

[o] 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

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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: _____

_____

_____

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Georgia High School Association
Student/Parent Concussion Awareness Form

SCHOOL: _____

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
- 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: 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.

By signing this concussion form, I 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 2024-2025 school year. This form will be stored with the athletic physical form and other accompanying forms required by the _____School System.

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

_____	_____	_____
Student Name (Printed)	***Student Name (Signed)***	***Date***
_____	_____	_____
Parent Name (Printed)	***Parent Name (Signed)***	***Date***

(Revised: 3/24)

Georgia High School Association
Student/Parent Sudden Cardiac Arrest Awareness Form

SCHOOL: _____

1: Learn the Early Warning Signs

If you or your child has had one or more of these signs, see your primary care physician:

- Fainting suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones
- Unusual chest pain or shortness of breath during exercise
- Family members who had sudden, unexplained and unexpected death before age 50
- Family members who have been diagnosed with a condition that can cause sudden cardiac death, such as hypertrophic cardiomyopathy (HCM) or Long QT syndrome
- A seizure suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones

2: Learn to Recognize Sudden Cardiac Arrest

If you see someone collapse, assume he has experienced sudden cardiac arrest and respond quickly. This victim will be unresponsive, gasping or not breathing normally, and may have some jerking (Seizure like activity). Send for help and start CPR. You cannot hurt him.

3: Learn Hands-Only CPR

Effective CPR saves lives by circulating blood to the brain and other vital organs until rescue teams arrive. It is one of the most important life skills you can learn – and it's easier than ever.

- Call 911 (or ask bystanders to call 911 and get an AED)
- Push hard and fast in the center of the chest. Kneel at the victim's side, place your hands on the lower half of the breastbone, one on top of the other, elbows straight and locked. Push down 2 inches, then up 2 inches, at a rate of 100 times/minute, to the beat of the song "Stayin' Alive."
- If an Automated External Defibrillator (AED) is available, open it and follow the voice prompts. It will lead you step-by-step through the process, and will never shock a victim that does not need a shock.

By signing this sudden cardiac arrest form, I give _____ High School permission to transfer this sudden cardiac arrest form to the other sports that my child may play. I am aware of the dangers of sudden cardiac arrest and this signed sudden cardiac arrest form will represent myself and my child during the 2024-2025 school year. This form will be stored with the athletic physical form and other accompanying forms required by the _____School System.

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

_____	_____	_____
Student Name (Printed)	***Student Name (Signed)***	***Date***
_____	_____	_____
Parent Name (Printed)	***Parent Name (Signed)***	***Date***

(Revised: 3/24)

PLAYER AND PARENT/GUARDIAN CONTRACT

PLAYER

As a member of this team, I agree to follow this code of conduct:

- I will respect the game by playing fairly and to the best of my ability.
- I will lead by example, practice good sportsmanship and demonstrate self-control.
- I will not criticize calls made by officials and will allow my coach to handle any issues with them.
- I will always support and encourage my teammates and prioritize the team's success over my own.
- I will represent my team with class, handle winning and losing with grace, and ensure that my behavior always reflects positively on my teammates, coaches and school.
- I will accept that mistakes are a part of sports and will use them as opportunities to grow.

PARENT/GUARDIAN

As a team parent/guardian, I agree to follow this code of conduct:

- I will encourage my child to play fairly and to the best of their ability.
- I will practice good sportsmanship by demonstrating positive support for all players, coaches, fans and officials.
- I will not criticize calls made by officials and will allow the coach to handle any issues with them.
- I will prioritize the emotional and physical well-being of my child above any personal desire to win.
- I will do my best to make high school sports fun for my child and help them enjoy the experience.
- I will remember the game is for the players and not for the adults.

We will always do our best to follow this code of conduct because we know it is meant to help students become better players, teammates and people.

PLAYER SIGNATURE _____ **DATE** _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

BenchBadBehavior.com

BENCH BAD BEHAVIOR

NFHS

GHSA

Consent to Treatment and Waiver of Liability Form

I _____ [Name of Parent or Guardian] am the parent or legal guardian of _____ [Name of Student]. I understand that Southeast Georgia Health System provides athletic training, first aid and certain other medical services in connection with certain athletic events and programs of the Glynn County School System ("GCSS"). In case of emergency or accident on the school grounds or during any school activity involving the above-name student, which in the opinion of school authorities or personnel of Southeast Georgia Health System present requires immediate medical or surgical attention, I hereby grant permission to such school authorities and Southeast Georgia Health System personnel to render medical treatment and to obtain the services of qualified medical personnel to treat the condition unless I am present and request otherwise or until I later request otherwise.

I also hereby release and agree to hold harmless GCSS, Southeast Georgia Health System, and their employees and agents, including, but not limited to, the Athletic Trainers and the Team Physicians or Team Physician Assistants, from any and all liability in case of accident, injury, damage or other mishap in connection with all medical services or athletic trainer services they provide to the above-named student.

_____ _____ _____

Parent/Guardian Signature* Telephone Number Date

Authorization for Release of Medical Information

I authorize the release of medical information to GCSS by physicians and health care providers ("providers") rendering services to GCSS athletes. The purpose of the release of medical information is to allow GCSS to determine the advisability of an athlete's participation in GCSS athletics. An example would be the release of a screening physical examination. By agreeing to this release of medical information for my son, daughter or other person for whom I have the legal authority to act, I hereby authorize health care providers (including, but not limited to, Southeast Georgia Health System and its physicians and athletic trainers) that are contracted with GCSS to release to each other and to GCSS oral and written information relating to the athlete's medical or physical condition, illness or injury that may have a bearing upon past, present, or future participation in athletics of GCSS. The medical information will be used by GCSS for the purposes of determining the advisability of the athlete's participation in GCSS athletics.

This authorization is expressly bound by the following conditions:

- This authorization will automatically expire upon the athlete's termination of participation in or ineligibility to participate in GCSS athletics, except to the extent relied upon for disclosures made prior to the automatic expiration.

- This authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to the appropriate Athletic Director. As soon as practicable, GCSS shall inform each contracted health care provider of each athlete's revocation. However, any such revocation shall not affect disclosures made by a health care provider prior to that health care provider's receipt of the revocation from GCSS. In addition, such revocation shall not affect disclosures made prior to the receipt of the revocation to the extent that this authorization was relied upon for such disclosures.

- This authorization is not intended to alter the athlete's ability to receive medical care from any health care provider regardless of whether or not this authorization is agreed to or refused.

- This authorization shall cover actions by and for Southeast Georgia Health System, Cooperative Healthcare Services, Inc. and all of their respective employees, workforce and business associates and all other physicians and healthcare providers contracted with GCSS and their respective employees, workforce and business associates.

_____ _____ _____

Parent/Guardian Signature* Telephone Number Date

* This authorization must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the student's behalf. **By signing this form, you as the parent, guardian or a party acting in loco parentis warrant that you have the legal authority to act on the Athlete's behalf.** The signature may be only the athlete if the athlete is over 18 years of age.

GLYNN COUNTY SCHOOLS DRUG TESTING CONSENT

Mandatory Student Drug Testing: JCABB

The Glynn County Board of Education firmly believes that the use and abuse of drugs that are not prescribed or used as prescribed are detrimental to the physical, emotional, and mental well-being of its students. The Board further believes that this abuse seriously interferes with the academic and athletic performance of students and creates an unhealthy learning environment. These concerns have prompted the Board to authorize the Superintendent and his/her administrative staff to develop and implement drug screening procedures for all students who wish to participate in any interscholastic athletic or extracurricular activity, or for any student who applies for a parking permit and intends to park a vehicle on school grounds of Glynn County Schools.

A. **Guidelines for Mandatory Drug Testing**:

Administrators shall not utilize information obtained in the course of administering the policy for disciplinary purposes other than those set forth in this policy. This policy is not designed to be used in any manner, voluntarily or involuntarily, to provide a source of information for law enforcement agencies or for the prosecution of the student. The Principal shall not release test results of any person other than those described within this policy or as required by law or a lawfully issued subpoena or court order.

B. Applicability:

This policy applies to all students involved in competitive interscholastic activities in grades 9 through 12. These activities include but are not limited to athletics, band, cheerleading. Any student that elects to participate in any of these programs/activities with parental consent will be subject to random drug testing in accordance with this policy. The random test will be conducted in season and out of season. Random testing/screening may take place at any time during the school year from the beginning of classes. Upon completion of the consent form, the student will automatically be entered in the testing pool for the entire year.

C. Confidentiality:

The Glynn County School System shall not release records of drug test/screen or any resulting actions to anyone other than the student's parents, as defined by Georgia statutes, school officials, and the head coach/sponsor without the written authorization from the parent/guardian or the student, if the student is over 18 years of age. Additionally, the District respects the privacy of its students and shall maintain confidentiality regarding any drug testing/screening under this policy.

Compliance with the requirements of the Student Drug Testing Policy are mandatory. A copy of the policy and regulation has been made available for review, and I have read and understand its terms and provisions. My signature below indicates that I fully understand the statements above and that I fully consent to my child participating in the Drug Testing Program.

Check all that apply:

☐ BASEBALL	☐ BASKETBALL	☐ CHEERLEADING	☐ CROSS COUNTRY	☐ FOOTBALL
☐ GOLF	☐ LITERARY	☐ MARCHING BAND	☐ ONE ACT	☐ PARKING PERMIT
☐ SOCCER	☐ SOFTBALL	☐ SWIMMING	☐ TENNIS	☐ TRACK & FIELD
☐ VOLLEYBALL	☐ WRESTLING			

Parent/Guardian Name (Print): _____ Signature: _____

Student Name (Print): _____ Signature: _____

Student ID Number: _____ Date: _____

REVISED: May 29, 2019

Notes