## ATLANTA PUBLIC SCHOOLS ATHLETICS

Please read and complete each section of this document. Form must be completed before students are cleared to participate.

**Part I** **PARENT CONSENT FOR ATHLETIC PARTICIPATION AND EMERGENCY MEDICAL TREATMENT**

I, _____, parent or guardian, hereby gives consent for my child or ward, _____ to compete in middle school or high school athletics for _____ Middle/High School. Should at any time I desire said student to refrain from participating, I will notify the athletic director or head coach of said school in writing. I fully understand insurance coverage and limitations. Also, in consideration of my son's/daughter 's opportunity to participate in interscholastic activities, I hereby consent to emergency medical treatment, hospitalization or other medical treatment as may be necessary for the welfare of the above-named child, by a physician, qualified nurse, and/or hospital, in the event of injury or illness during all periods of time in which the student is away from his/her legal residence as a member of an interscholastic activity team or group, and hereby waive on behalf of myself and the above-named child any liability of The Atlanta Board of Education, any of its agents or employees, arising out of such medical treatment.

**WARNING: BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OF INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH. PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM.**

By signing this Form, I acknowledge that I have read and understand this warning and consent for participation and emergency medical treatment.

Parent's or Guardian's Signature _____ Date _____

**Part II**

**PLEASE CHECK ONE OF THE FOLLOWING INSURANCE OPTIONS**

☐ ☐ **OPTION NO. 1:** I hereby certify that my child or ward, (name)_____ is a member of a group or to her private hospital and medical plan and/or Medicaid and is covered by that policy or plan for injuries, which may occur from athletic participation. Coverage there under is provided by (name of Company) _____, under Policy No. _____. I understand and affirm that, in light of my selection of this Option, the Atlanta Board of Education has relied upon this certification by me in allowing my child or ward to participate in middle/high school athletics. I will notify the Atlanta Board of Education in writing of any changes in coverage within ten (10) days of said change.

☐ ☐ **OPTION NO. 2: I hereby certify that my child or ward, _____is not a member of a group or other private hospital and medical plan, including Medicaid, and is not covered by any policy or plan for injuries which may occur from athletic participation.** I understand the Atlanta Public School System will make available *limited* excess medical coverage as per insurance outline/overview for my child or ward in consideration for premium in the amount of $12.00 for Varsity, Jr. Varsity and Middle School Athletics paid by me on behalf of my child or ward. I further understand that no payment will be made for any medical expense incurred after the policy period expires on June 30, 2012__, regardless of the date of my child's/ward's injury. All medical expenses incurred must be submitted no later than June 1, 2012__. All medical expenses are excess over any other valid insurance including Medicaid. I understand that I am responsible for the filing of any and/or all medical claims. I have read and understand the benefits and exclusions.

**NOTE: THERE CAN BE NO PARTICIPATION IN THE ATHLETIC PROGRAMS OF THE ATLANTA PUBLIC SCHOOLS UNLESS THE STUDENT IS COVERED BY A GROUP PLAN, MEDICAID OR IN THE EVENT OF NO INSURANCE, THE LIMITED EXCESS BENEFIT PLAN MADE AVAILABLE THROUGH THE ATLANTA PUBLIC SCHOOLS.**

I understand and affirm my selection of this option.
Parent's or Guardian's Signature _____ Date_____

**Part III**

**STUDENT MEDIA RELEASE FORM**

I hereby agree to allow my child, _____, to be photographed, videotaped and/or voice recorded and for his/her name, image, likeness and voice to used APS approved photographs, videos, publications, news media and web pages for special projects or publicity aimed at promoting school activities and sound teaching practices.

I am aware that my child may be asked a variety of questions concerning school and school-related activities and programs, and that the contents of the interview may be published or aired publicly. I understand that my child will be under the supervision of a school staff member during the interview or photo session, though not if the photographs or video or voice recordings are part of a general background scene in which my child is not identified.

My child reserves the right to refuse to answer any questions or participate in any discussions that make him/her feel uncomfortable or embarrassed. Additionally, my child and/or the supervising school agent reserves the right to terminate the interview, photo or video session at any time if said activities cause embarrassment or discomfort to my child.

I understand that neither APS, nor the news media, has any obligation to air or publish the image, photos, videotape and/or voice of my child. I also understand that neither my child nor I will receive any monetary compensation for the rights granted herein. And I understand that my child's appearance or the use of his/her voice in any publication, photo or televised form does not confer any ownership rights on my child or me.

If by reason of my child's statements and actions in the interview, photos, images, videotape and/or voice recording, or the materials furnished to my child for the same, there is any claim or litigation involving any charge by third parties of violation or infringement of their right, I agree to indemnify and hold harmless Atlanta Public Schools, its staff and its licensees, and assigns from liability, loss or expenses arising from such claim or litigation.

Parent's or Guardian's 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<br>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency) | ☐ | |
| Eyes, ears, nose, and throat<br>• Pupils equal<br>• Hearing | ☐ | |
| Lymph nodes | ☐ | |
| Heart[a]<br>• Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver) | ☐ | |
| Lungs | ☐ | |
| Abdomen | ☐ | |
| Skin<br>• 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<br>• 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: _____

_____

_____