

# GWINNETT COUNTY CONSENT and INSURANCE FORM

## PARENTAL CONSENT FOR ATHLETIC PARTICIPATION

**WARNING:** Although participation in supervised interscholastic athletics and activities may be one of the least hazardous in which students will engage in or out of school, **BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS INCLUDES A RISK OR INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG TERM CATASTROPHIC, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH.** Although serious injuries are not common in supervised school athletic programs, it is possible only to minimize, not eliminate the risk.

Participants can and have the responsibility to help reduce the chance of injury. **PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR EQUIPMENT DAILY.**

By signing this permission form, you acknowledge that you have read and understand this warning. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM.**

I (we) hereby give consent for \_\_\_\_\_ to:

- (1) Compete in athletics at \_\_\_\_\_ High School of the Gwinnett County School District in Georgia High School Association approved sports.
- (2) To accompany any school team of which the student is a member on any of its local or out-of-town trips;
- (3) and, I hereby verify that the information on both sides of this form is correct and understand that any false information may result in my son/daughter being declared ineligible.

The student is domiciled at the above address located in the \_\_\_\_\_ High School District.

Have you attended this Gwinnett County school for at least one full school year? Yes \_\_\_\_ No \_\_\_\_

You live with (name of parent/parents/guardian)

\_\_\_\_\_  
Date of birth \_\_\_\_\_ Telephone \_\_\_\_\_

\_\_\_\_\_  
Date entered 9th grade \_\_\_\_\_ Your grade level this year \_\_\_\_\_

This acknowledgment of risk and consent to allow participation shall remain in effect until revoked in writing.

**SIGNATURE(S) OF PARENT(S) OR GUARDIAN(S)**

\_\_\_\_\_

**INSURANCE INFORMATION**

Please INITIAL one of the following statements regarding insurance coverage for your son/daughter for the \_\_\_\_\_ school year, then sign below.

\_\_\_\_\_ My son/daughter is adequately and currently covered by accident insurance that will cover injuries sustained while participating in interscholastic athletics (including, but not limited to, varsity and junior varsity football).

Company providing insurance: \_\_\_\_\_

Name of insured: \_\_\_\_\_

Policy#: \_\_\_\_\_

\_\_\_\_\_ I wish to purchase the Benefit Plan provided by the Gwinnett County School System. (A signed copy of this Benefit Plan should be stapled to this form.)

**SIGNATURE(S) OF PARENT(S) OR GUARDIAN(S)**

\_\_\_\_\_

**AUTHORIZATION**

I certify that the medical history on this form is complete and accurate. I understand that this will serve as the basis for determining that my child, \_\_\_\_\_, may compete in high school athletics in Gwinnett County Schools. I also understand that this medical evaluation is only to determine fitness for athletics and is not to take the place of regular medical examinations. In case of an emergency or accident on the school grounds or during any school activity involving my child, \_\_\_\_\_, which in the opinion of school authorities present requires immediate medical or surgical attention, I hereby grant permission to physicians, consulting physicians, athletic trainers, emergency medical technicians, and other healthcare providers selected by school authorities to provide medical care and treatment (including hospitalization if deemed appropriate by school authorities or an appropriate healthcare provider) unless I am present and request otherwise or until I later request otherwise.

**SIGNATURE(S) OF PARENT(S) OR GUARDIAN(S)** \_\_\_\_\_

Date \_\_\_\_\_

Relation to Student: Mother \_\_\_\_\_ Father \_\_\_\_\_ Other \_\_\_\_\_

# Preparticipation Physical Evaluation

# HISTORY FORM

Date of Exam \_\_\_\_\_

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

Grade \_\_\_\_\_ School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Personal Physician \_\_\_\_\_

**In case of emergency, contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_

**Explain "Yes" answers below.  
Circle questions you don't know the answers to.**

- |  | Yes                      | No   |           |       |            |               |            |
|--|--------------------------|--|-----------|-------|------------|---------------|------------|
| 1. Has a doctor ever denied or restricted your participation in sports for any reason?   | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 2. Do you have an ongoing medical condition (like diabetes or asthma)?   | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?   | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects?  | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 5. Have you ever passed out or nearly passed out DURING exercise?  | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 6. Have you ever passed out or nearly passed out AFTER exercise?   | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise?  | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 8. Does your heart race or skip beats during exercise?   | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 9. Has a doctor ever told you that you have (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 |           |       |            |               |            |
| 10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)  | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 11. Has anyone in your family died for no apparent reason?   | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 12. Does anyone in your family have a heart problem?   | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 13. Has any family member or relative died of heart problems or of sudden death before age 50?   | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 14. Does anyone in your family have Marfan syndrome?   | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 15. Have you ever spent the night in a hospital?   | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 16. Have you ever had surgery?   | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 17. Have you ever had an injury, like a sprain, muscle or ligament tear, or tendinitis, that caused you to miss a practice or game? If yes, circle affected area below:          | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:   | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 19. Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below: | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| Head   | Neck                     | Shoulder                                   | Upper Arm | Elbow | Forearm    | Hand/ Fingers | Chest      |
| Upper Back   | Lower Back               | Hip  | Thigh     | Knee  | Calf/ Shin | Ankle         | Foot/ Toes |
| 20. Have you ever had a stress fracture?   | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?   | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 22. Do you regularly use a brace or assistive device?  | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |
| 23. Has a doctor ever told you that you have asthma or allergies?  | <input type="checkbox"/> | <input type="checkbox"/>                   |           |       |            |               |            |

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 24. Do you cough, wheeze, or have difficulty breathing during or after exercise?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Is there anyone in your family who has asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have you ever used an inhaler or taken asthma medicine?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ?             | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you had infectious mononucleosis (mono) within the last month?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any rashes, pressure sores, or other skin problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you had a herpes skin infection?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have you ever had a head injury or concussion?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you been hit in the head and been confused or lost your memory?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Do you have headaches with exercise?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?     | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you ever been unable to move your arms or legs after being hit or falling?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. When exercising in the heat, do you have severe muscle cramps or become ill?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you had any problems with your eyes or vision?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you wear glasses or contact lenses?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you wear protective eyewear, such as goggles or a face shield?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Are you happy with your weight?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Are you trying to gain or lose weight?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Has anyone recommended you change your weight or eating habits?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. Do you limit or carefully control what you eat?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Do you have any concerns that you would like to discuss with a doctor?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>FEMALES ONLY</b>  |                          |                          |
| 47. Have you ever had a menstrual period?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. How old were you when you had your first menstrual period? _____                                       |                          |                          |
| 49. How many periods have you had in the last 12 months? _____   |                          |                          |
| <b>Explain "Yes" answers here:</b>   |                          |                          |
| _____  |                          |                          |
| _____  |                          |                          |
| _____  |                          |                          |
| _____  |                          |                          |

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 \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ % Body Fat (optional) \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_ / \_\_\_\_ (\_\_\_\_ / \_\_\_\_ , \_\_\_\_ / \_\_\_\_)

Vision R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

	NORMAL	ABNORMAL FINDINGS	INITIALS*
<b>MEDICAL</b>			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
<b>MUSCULOSKELETAL</b>			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			

\*Multiple-examiner set-up only.

+Having a third party present is recommended for the genitourinary examination.

Notes: \_\_\_\_\_  
 \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

# Preparticipation Physical Evaluation

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- Not Cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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# Preparticipation Physical Evaluation

**CLEARANCE FORM**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Date of birth \_\_\_\_\_

- Cleared without restriction
- Cleared, with recommendations for further evaluation or treatment for: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- Not Cleared for  All sports  Certain sports: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

## EMERGENCY INFORMATION

Allergies \_\_\_\_\_

Other Information \_\_\_\_\_

Name of physician (print/type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of physician \_\_\_\_\_, MD or DO

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