

ATLANTA PUBLIC SCHOOLS

Department of Health, Physical Education and Athletics

Read and complete each section of this document. All student athletes must complete this form before cleared to participate.

Part I PARENT CONSENT FOR ATHLETIC PARTICIPATION AND EMERGENCY MEDICAL TREATMENT

I, _____ (parent or guardian) hereby give consent for my child or ward (child's name) _____ 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 INSURANCE OPTIONS (Please check one of the following options.)

[] OPTION NO. 1: I hereby certify that my child or ward (child's name) _____ is a member of a group or other 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 (child's name) _____ 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 participation 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, 2006, regardless of the date of my child's/ward's injury. All medical expenses incurred must be submitted no later than June 1, 2006. 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 (name) _____, to be photographed, videotaped and/or voice recorded and for his/her name, image, likeness and voice to be used for 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 The Atlanta Public Schools, 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 The 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

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		Yes	No					
1. Has a doctor ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	24. Do you cough, wheeze, or have difficulty breathing during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>					
2. Do you have an ongoing medical condition (like diabetes or asthma)?	<input type="checkbox"/>	<input type="checkbox"/>	25. Is there anyone in your family who has 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"/>	26. Have you ever used an inhaler or taken asthma medicine?	<input type="checkbox"/>	<input type="checkbox"/>					
4. Do you have allergies to medicines, pollens, foods, or stinging insects?	<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"/>					
5. Have you ever passed out or nearly passed out DURING exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Have you had infectious mononucleosis (mono) within the last month?	<input type="checkbox"/>	<input type="checkbox"/>					
6. Have you ever passed out or nearly passed out AFTER exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29. Do you have any rashes, pressure sores, or other skin problems?	<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"/>	30. Have you had a herpes skin infection?	<input type="checkbox"/>	<input type="checkbox"/>					
8. Does your heart race or skip beats during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	31. Have you ever had a head injury or concussion?	<input type="checkbox"/>	<input type="checkbox"/>					
9. Has a doctor ever told you that you have (check all that apply):			32. Have you been hit in the head and been confused or lost your memory?	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> High blood pressure		<input type="checkbox"/> A heart murmur	33. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/> High cholesterol		<input type="checkbox"/> A heart infection	34. Do you have headaches with exercise?	<input type="checkbox"/>	<input type="checkbox"/>					
10. Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram)	<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"/>					
11. Has anyone in your family died for no apparent reason?	<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"/>					
12. Does anyone in your family have a heart problem?	<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"/>					
13. Has any family member or relative died of heart problems or of sudden death before age 50?	<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"/>					
14. Does anyone in your family have Marfan syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	39. Have you had any problems with your eyes or vision?	<input type="checkbox"/>	<input type="checkbox"/>					
15. Have you ever spent the night in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you wear glasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>					
16. Have you ever had surgery?	<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"/>					
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"/>	42. Are you happy with your weight?	<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"/>	43. Are you trying to gain or lose weight?	<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"/>	44. Has anyone recommended you change your weight or eating habits?	<input type="checkbox"/>	<input type="checkbox"/>					
Head	Neck	Shoulder	Upper Arm	Elbow	Forearm	Hand/ Fingers	Chest	45. Do you limit or carefully control what you eat?	<input type="checkbox"/>	<input type="checkbox"/>
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes	46. Do you have any concerns that you would like to discuss with a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
								FEMALES ONLY		
								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? _____		
20. Have you ever had a stress fracture?	<input type="checkbox"/>	<input type="checkbox"/>	Explain "Yes" answers here: _____							
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"/>	_____							

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*
MEDICAL			
Appearance			
Eyes/ears/nose/throat			
Hearing			
Lymph nodes			
Heart			
Murmurs			
Pulses			
Lungs			
Abdomen			
Genitourinary (males only)+			
Skin			
MUSCULOSKELETAL			
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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