## **Chattooga County Athlete Physical Insurance and Consent Form**

*Parents Signature needed in TH PLEASE PRINT	REE places GRADE		(Nickname if any)
Name			
(Last)	(First) CONTAC	T INFO	(Middle)
HOME:	CELL:		<u>:</u>
	WHO:		WHO:
*********	********	******	*****
	ENTAL CONSENT FOR		EIPATION  E may be one of the least hazardous in which
students will engage in or out of school, BY INCLUDES A RISK OF INJURY W CATASTROPHIC, INCLUDING PE injuries are not common in supervised school Participants can and have the res RULES, REPORT ALL PHYSICAL PROGRAM, AND INSPECT THEIR	ITS NATURE, PARTICITY ITS NATURE, PARTICITY ITS NATURE, PARALYSIS OF A CONTROL OF THE PARALYSIS OF THE PARAL	IPATION IN INTER- SEVERITY FROM M S FROM THE NECK ble only to minimize, not e hance of injury. PLAYE & COACHES, FOLLO	SCHOLASTIC ATHLETICS INOR TO LONG TERM DOWN OR DEATH. Although serious eliminate the risk. RS MUST OBEY ALL SAFETY
WHO DO NOT WISH TO ACCEPT PERMISSION FORM.			
I (We) hereby give consent for my child,		to: t in Georgia	
Cheerleading Basketball	Softball Tra	ick & Field	
Volleyball We	eight Training Football	Wrestling	Tennis
<ul> <li>(2) Accompany any school team of</li> <li>(3) I hereby verify that the information</li> <li>(3) I hereby verify that the information</li> <li>(4) and, I consent to Internet storation</li> </ul>	ation on both sides/pages of this neligible;	s form is correct and unde	erstand that any false information may result i
This acknowledgement of risk and			
This acknowledgement of risk and SIGNATURE(S) OF PARENT(S) OR G	consent to allow participa	ation shall remain in	effect until revoked in writing.
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This acknowledgement of risk and a SIGNATURE(S) OF PARENT(S) OR G (Use Ink)  Please INITIAL one of the following statements of the school authorized activities (included company Providing Insurance)  I have purchased School Insurance. Policy of the school authorized activity involving my child, which in the opinic permission to said school authorities to obtas school authorities. I hereby grant permission request otherwise.	INSURANCE IN regarding insurance coverage for y d currently covered by accident ling but not limited to, Football). Name of Insure licy Number  RDIAN(S)  Date:  AUTHOR is complete and accurate. I une athletics program. I also unders cal examinations. In case of an ele ion of school authorities presen ain the services of the physician n, also, to said physicians to tre Il remain in effect until revoked	NFORMATION your son/daughter for the so t insurance that will cover ed  IZATION derstand that this will sen stand that this medical ev emergency or accident or it requires immediate med or to transport my child, eat said condition unless I	effect until revoked in writing.  Date:  Chool year, then sign below.  Injuries sustained while participating in any Policy Number  Policy Number  ve as the basis for determining that my child raluation is only to determine fitness for athleting the school grounds or during any school dical or surgical attention, I hereby grant to the hospital if it is deemed necessary by

## **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.)

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		hereby state that, to the best of my knowledge, my answers to	the above	questic	ons are complete and correct.		

## PHYSICAL EXAMINATION FORM

PHYSICAL 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?			
<ul><li>Do you feel safe at your home or residence?</li><li>Have you ever tried cigarettes, chewing tobacco, snuff, or dip?</li></ul>			
<ul> <li>During the past 3D days, did you use chewing tobacco, snuff, or dip?</li> </ul>			
<ul><li>Do you drink alcohol or use any other drugs?</li><li>Have you ever taken anabolic steroids or used any other pertormance supplement?</li></ul>			
<ul> <li>Have you ever taken any supplements to help you gain or lose weight or improve you</li> </ul>	ur pertormance?		
<ul> <li>Do you wear a seat belt, use a helmet, and use condoms?</li> <li>Consider reviewing questions on cardiovascular symptoms (questions 5-14).</li> </ul>			
EXAMINATION			
Height Weight	☐ Male ☐Female		
BP / ( / ) Pulse	Vision R 20/	L 20/ Corrected DY DN	
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance  Martan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyl)			
arm span> height, hyperlaxity, myopia, MVp,aortic insufficiency)	y,		
Eyes/ ears/ nose/throat			
Pupils equal     Hearing			
Lymph nodes			
Heart'			
Murmurs (auscultation standing, supine, +/- Valsalva)			
Location of point of maximal impulse (PMI)  Pulses		+	
Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only)b			
Skin  • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic'			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional  • Duck-walk, single leg hop			
Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam. bConsider in private setting. Having third party present is recommended.	GU exam If		
'Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.			
☐Cleared for all sports without restriction			
$\begin{tabular}{l} \Box \textbf{Cleared for all sports without restriction with recommendations for further evaluation or } \\$	treatment for		
□Not cleared			
☐ Pending further evaluation			
For any sports			
For certain sports			<del></del>
Reason			
Recommendations			
I have examined the above-named student and completed the preparticipation phys sport(s) as outlined above. A copy of the physical exam is on record in my office an cleared for participation, the physician may rescind the clearance until the problem	d can be made available to the sch	ool at the request of the parents. If conditions arise after	er the athlete has be
Name of physician (print/type)		Date	
Address		Phone	
North and Administra			L/D
Signature of physician			MD or DO

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

## **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 fur	ther evaluation or treatment for			
	☐ Not cleared				
	Pending further evaluation				
	☐ For any sports				
	☐ For certain sports				
	Reason				
Recom	mendations				
contra	examined the above-named student and completed the prepaindications to practice and participate in the sport(s) as outlible to the school at the request of the parents. If conditions a	lined above. A copy of the	physical exan	n is on record in my office and	d can be made
	nce until the problem is resolved and the potential conseque				may resemu me
Name c	of physician (print/type)			Date	
	S				
	re of physician				
EMEF	RGENCY INFORMATION				
Allergie	s				
Other in	nformation				
Other in	nformation				
Other in	nformation				
Other in	nformation				
Other in	nformation				
Other in	nformation				<u> </u>
Other in	nformation				