

Last Name _____ First Name _____ MI _____ Grade _____ Student No. _____



GWINNETT COUNTY PUBLIC SCHOOLS

ATHLETICS

MEDICAL PHYSICAL FORM

CONSENT TO PARTICIPATE

INSURANCE INFORMATION

(GEORGIA HIGH SCHOOL ASSOCIATION)

Preparticipation Physical Evaluation

HISTORY FORM

Date of Exam _____

STUDENT NUMBER _____

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? YES NO
 2. Do you have an ongoing medical condition (like diabetes or asthma)? YES NO
 3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? YES NO
 4. Do you have allergies to medicines, pollens, foods, or stinging insects? YES NO
 5. Have you ever passed out or nearly passed out DURING exercise? YES NO
 6. Have you ever passed out or nearly passed out AFTER exercise? YES NO
 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? YES NO
 8. Does your heart race or skip beats during exercise? YES NO
 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) YES NO
 11. Has anyone in your family died for no apparent reason? YES NO
 12. Does anyone in your family have a heart problem? YES NO
 13. Has any family member or relative died of heart problems or of sudden death before age 50? YES NO
 14. Does anyone in your family have Marfan syndrome? YES NO
 15. Have you ever spent the night in a hospital? YES NO
 16. Have you ever had surgery? YES NO
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: YES NO
 18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below: YES NO
 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: YES NO

| | | | | | | | |
|------------|------------|----------|-----------|-------|-----------|--------------|-----------|
| 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? YES NO
 21. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? YES NO
 22. Do you regularly use a brace or assistive device? YES NO
 23. Has a doctor ever told you that you have asthma or allergies? YES NO
24. Do you cough, wheeze, or have difficulty breathing during or after exercise? YES NO
 25. Is there anyone in your family who has asthma? YES NO
 26. Have you ever used an inhaler or taken asthma medicine? YES NO
 27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? YES NO
 28. Have you had infectious mononucleosis (mono) within the last month? YES NO
 29. Do you have any rashes, pressure sores, or other skin problems? YES NO
 30. Have you had a herpes skin infection? YES NO
 31. Have you ever had a head injury or concussion? YES NO
 32. Have you been hit in the head and been confused or lost your memory? YES NO
 33. Have you ever had a seizure? YES NO
 34. Do you have headaches with exercise? YES NO
 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? YES NO
 36. Have you ever been unable to move your arms or legs after being hit or falling? YES NO
 37. When exercising in the heat, do you have severe muscle cramps or become ill? YES NO
 38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? YES NO
 39. Have you had any problems with your eyes or vision? YES NO
 40. Do you wear glasses or contact lenses? YES NO
 41. Do you wear protective eyewear, such as goggles or a face shield? YES NO
 42. Are you happy with your weight? YES NO
 43. Are you trying to gain or lose weight? YES NO
 44. Has anyone recommended you change your weight or eating habits? YES NO
 45. Do you limit or carefully control what you eat? YES NO
 46. Do you have any concerns that you would like to discuss with a doctor? YES NO
- FEMALES ONLY**

 47. Have you ever had a menstrual period? YES NO
 48. How old were you when you had your first menstrual period? YES NO
 49. How many periods have you had in the last 12 months? YES NO
- Explain "Yes" answers here:** _____
- _____
- _____
- _____

I hereby state that, to the best of 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 R20/ _____ L20/ _____ 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 on!y)+ | | | |
| 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.

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

CLEARANCE FORM

- Not Cleared for All sports Certain sports: _____ Reason: _____
- Recommendations: _____

EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) Dr. David Wiley Date _____

Address 465 Decatur Rd. Suite I Decatur, GA Phone 770-822-1922

SIGNATURE OF PHYSICIAN _____ **MD OR DO**

GWINNETT COUNTY CONSENT, INSURANCE AND ATHLETIC PHYSICAL 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 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 said school authorities to obtain the services of a physician or to transport said child to the hospital if it is deemed necessary by school authorities. I hereby grant permission, also, to said physicians to treat said condition 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 _____