

Fulton County School Transportation Release

Since your student will be transported between school sites, events, activities during and after the school day, please complete and sign the following form, and return it to your coach.

___ I wish for my student to be transported by Fulton County bus transportation ONLY.

___ I wish to designate additional person(s) who may transport my student (see below).

I agree to hold Fulton County Board of Education harmless in the event of injury to _____ (student's name), including any property damage while the student is driving or being driven to or from a school site and/or to school-related events, activities, or sites after school hours in a vehicle other than that provided by Fulton County Board of Education.

In addition, I agree not to assert against the Fulton County Board of Education, all current, former and future members of the School Board of the Fulton County Board of Education, all current, former and future employees and/or volunteers of the Fulton County Board of Education, and their heirs, executors, administrators, successors, and assigns, in any court of law, any claim or claims that the student and/or parent or legal guardian had, now have, or may have in the future, whether known or unknown, based on any injuries sustained by the student while being so transported.

I have read the above agreement, and voluntarily sign the release and waiver of liability, and further agree that no oral representations, statements or inducements apart from the foregoing written agreement have been made.

Signature of Parent or Legal Guardian: _____ Date: _____

Signature of Student Athlete: _____ Date: _____

Designated Driver (if applicable): All designated drivers must be over 18 years of age or an immediate family relative.

(Student's Name) _____ has my permission to be transported to and from school sites during the school day and/or to school-related events, activities, or sites after school hours as a participant on the _____ School _____ Team. Either I or my designated driver, _____, will be transporting the student to and/or from the event or activity. Either I or my designated driver will present himself or herself to the head coach and/or assistant coach after the event or activity has been completed in order to verify the intent to transport the above mentioned student.

Signature of Parent or Legal Guardian: _____ Date: _____

Signature of Student Athlete: _____ Date: _____

Signature of Designated Driver: _____ Date: _____

(FOR SCHOOL USE ONLY)

Received by : _____ on _____
(print full name) (print date)

Signature of receiving party: _____

PRIOR TO PARTICIPATION IN ANY CONDITIONING, TRYOUT, PRACTICE SESSION, OR PLAY IN ANY INTERSCHOLASTIC ATHLETIC ACTIVITY, THE STUDENT ATHLETE MUST SUBMIT THIS FORM TO THE COACH OF THE ACTIVITY. FAILURE TO SUBMIT THIS FORM WILL DELAY THE ELIGIBILITY OF THE STUDENT-ATHLETE TO JOIN THE TEAM.

FULTON COUNTY SCHOOL SYSTEM DEPARTMENT OF ATHLETICS

STUDENT'S APPLICATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS AND VERIFICATION OF INSURANCE

Sport: _____ Date of first practice: _____, 2013/2014

Student Name: _____ Male ____ or Female ____
(Last name) (First name) (MI)

Date of Birth: _____ Age: _____ years old
(Month) (Day) (Year)

Address: _____
(# and Street Name) (City) (State) (Zip Code)

Home Telephone #: _____ Emergency Telephone # _____
Cellular Telephone #: _____

This application to represent my school in interscholastic activities is entirely voluntary on my part and is made with the understanding that I have studied and understood the Eligibility Standards that I must meet to represent my school and that I have not violated any of these standards. I understand that not meeting the standards set by the school or being ejected from an interscholastic contest because of an unsportsmanlike act, could result in my not being allowed to participate in the next contest or suspension from the team either temporarily or permanently. I understand that if I transfer to another school my eligibility may be affected under the Georgia High School Association's eligibility standards.

Student Signature: _____
(Signature) (School) (Date)

I hereby consent for the above student to represent his/her school in interscholastic activities. I have received a Student/Parent Handbook for GHSA Sanctioned Interscholastic Activities 2013-2014. I understand that I am responsible for reading the contents of this publication and that questions related to this publication can be addressed to the Fulton County Athletic Director at 404-763-6892. If I, the parent(s)/guardian(s), cannot be reached in the event of a medical emergency, I do give consent for the school to obtain emergency transportation to the physician or hospital of its choice, and such medical care as is reasonably necessary for the welfare of the student if he/she is injured in the course of participation in interscholastic activities. I give permission for the above student to participate in school-sponsored trips, including overnight trips, associated with Fulton County School's interscholastic athletic competitions. In the event that transportation is not provided by the Fulton County School System, transportation will be the student's or the parent's /guardian's responsibility. In addition, I agree not to assert against the Fulton County Board of Education, all current, former and future members of the School Board of the Fulton County Board of Education, all current, former and future employees and/or volunteers of the Fulton County Board of Education, and their heirs, executors, administrators, successors, and assigns, in any court of law, any claim or claims that the student and/or parent or legal guardian had, now have, or may have in the future, whether known or unknown, arising out of, during, or in conjunction with the student's participation in the activity, any trip, or transportation associated with the activity, or the rendering of emergency medical procedures or treatment, if any.

All parents and guardians must sign and date this form

Signature of parent/guardian: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

PRIOR TO PARTICIPATION IN ANY CONDITIONING, TRYOUT, PRACTICE SESSION, OR PLAY IN ANY INTERSCHOLASTIC ATHLETIC ACTIVITY, THE STUDENT-ATHLETE MUST SUBMIT THIS FORM FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS TO THE COACH OF THE ACTIVITY. FAILURE TO SUBMIT THIS FORM WILL DELAY THE ELIGIBILITY OF THE STUDENT-ATHLETE TO JOIN THE TEAM.

FULTON COUNTY SCHOOL SYSTEM DEPARTMENT OF ATHLETICS

VERIFICATION OF INSURANCE COVERAGE

Effective for School Year 2013-2014

I have waived the medical/health insurance coverage that has been approved by the Fulton County School System and offered to my child, _____ Date of Birth: _____ (Name of Child)

The medical/ health insurance that I am using for my child for the current school year at _____ is provided by _____ and (School Name) (Name of Insurance Company)

the insurance policy number is _____ . This insurance policy (Insurance Policy Number)

is in effect from: _____ to _____ (Date) (Date)

Attach a copy of Medical/Health Insurance Certificate to this form to verify information listed above. Thank you.

The above medical/health insurance coverage provides for the following interscholastic athletics activities:

- 1. _____ 2. _____ 3. _____ 4. _____

We/I understand that per The Georgia High School Association a Pre-participation Physical evaluation must be performed by a physician to medically screen each student who participates in the interscholastic athletic programs of the Fulton County School District. We/I understand that a basic medical screening (the required physical exam) is general in nature and limited in scope and does not indicate or assure me/us that my/our child is completely free from impairments. If I/we wish for a more detailed physical exam to be performed upon my/our child then it is my/our responsibility to arrange and to pay for such an exam. If this more detailed exam is performed, it is my/our responsibility to notify the Fulton County School District, and it's appropriate employees, of any potential medical problems uncovered by any physical exam given to my/our child other than the general physical required by the school system for athletic participation. I agree to fully waive any and all claims of whatever nature, fully and finally, now and forever, for my/our child, for myself, my estate, my heirs, my administrators, my executors, my assignees, my agents, my successors, and for all members of my family, and to indemnify, release, defend, exonerate, discharge and hold harmless all current, former and future members of the School Board of the Fulton County Board of Education, all current, former and future employees of the Fulton County Board of Education, their schools, their trustees, officers, Board of Education, agents, coaches, athletic trainers, physicians, volunteers, and any other practitioner of the healing arts (an "Indemnified Party") from any and all liability, personal or property damages, claims, causes of action or demands brought against the Fulton County School District or indemnified party arising out of any injuries to my/our child or to his or her property or losses of any kind which may result from or in connection with his or her participation in any activity related to the interscholastic athletic programs provided by the Fulton County School District.

My signature below attests that I have read, understood and concur with the information on this form, and that I give consent for my child to participate in the athletic programs as stated above.

ALL PARENTS/GUARDIANS/ MUST SIGN BELOW AND DATE

Signature of parent/guardian: _____ Date: _____

Signature of parent/guardian : _____ Date: _____

Signature of student : _____ Date: _____

PRIOR TO PARTICIPATION IN ANY CONDITIONING, TRYOUT, PRACTICE SESSION, OR PLAY IN ANY INTERSCHOLASTIC ATHLETIC ACTIVITY, THE STUDENT-ATHLETE MUST SUBMIT THIS FORM FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS TO THE COACH OF THE ACTIVITY. FAILURE TO SUBMIT THIS FORM WILL DELAY THE ELIGIBILITY OF THE STUDENT-ATHLETE TO JOIN THE TEAM

Pre-Participation Physical Evaluation-To Be Retained By Physician 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.)

Date of Exam: _____
 Name: _____ Date of Birth _____
 Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

Do you have any allergies? Yes No If yes, please identify specific allergy below.

Medicines Pollens Food Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, 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 <input type="checkbox"/> Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

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: _____

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Pre-Participation Physical Evaluation- To Be Retained By Physician

PHYSICAL EXAMINATION FORM

Name _____ Date of birth: _____

PHYSICIAN 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?
 - Do you feel safe at your home or residence?
 - Have you ever tried 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 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?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION			
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female	
BP / (/)	Pulse	Vision R 20/	L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS	
Appearance <ul style="list-style-type: none"> Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency) 			
Eyes/ears/nose/throat <ul style="list-style-type: none"> Pupils equal Hearing 			
Lymph nodes			
Heart ^a <ul style="list-style-type: none"> Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI) 			
Pulses <ul style="list-style-type: none"> Simultaneous femoral and radial pulses 			
Lungs			
Abdomen			
Genitourinary (males only) ^b			
Skin <ul style="list-style-type: none"> HSV, lesions suggestive of MRSA, tinea corporis 			
Neurologic ^c			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional <ul style="list-style-type: none"> Duck-walk, single leg hop 			

^aConsider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.

^bConsider GU exam if in private setting. Having third party present is recommended.

^cConsider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- 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 _____
- Reason: _____

Recommendations: _____

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

Pre-Participation Physical Evaluation CLEARANCE FORM

TO BE GIVEN TO COACH OF SPORT IN WHICH THE STUDENT ATHLETE WILL PARTICIPATE and KEPT ON FILE AT THE SCHOOL

Note: Copies of other Pre-Participation Evaluation forms may be obtained by the school only if parents/guardians sign a release of records form at the physician's office.

Name _____ Sex M F Age _____ Date of birth _____

- Cleared for all sports without restriction
 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 _____

Reason Recommendations

I have examined the above-named student and completed the pre-participation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician: _____, MD or DO

EMERGENCY INFORMATION

Allergies

Other information

STUDENT/PARENT CONCUSSION AWARENESS FORM

SCHOOL: _____

DANGERS OF CONCUSSION

Concussions at all levels of sports have received a great deal of attention and a state law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor “ding” to the head, it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long-term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial – that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GHSA athletics. One copy needs to be returned to the school, and one retained at home.

COMMON SIGNS AND SYMPTOMS OF CONCUSSION

Headache, dizziness, poor balance, moves clumsily, reduced energy level/tiredness

Nausea or vomiting

Blurred vision, sensitivity to light and sounds

Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments

Unexplained changes in behavior and personality

Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

BY-LAW 2.68: GHSA CONCUSSION POLICY: In accordance with Georgia law and national playing rules published by the National Federation of State High School Associations, any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion shall be immediately removed from the practice or contest and shall not return to play until an appropriate health care professional has determined that no concussion has occurred. (NOTE: An appropriate health care professional may include, licensed physician (MD/DO) or another licensed individual under the supervision of a licensed physician, such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.

- a) No athlete is allowed to return to a game or a practice on the same day that a concussion (a) has been diagnosed, OR (b) cannot be ruled out.
- b) Any athlete diagnosed with a concussion shall be cleared medically by an appropriate health care professional prior to resuming participation in any future practice or contest. The formulation of a gradual return to play protocol shall be a part of the medical clearance.
- c) It is mandatory that every coach in each GHSA sport participate in a free, online course on concussion management prepared by the NFHS and available at www.nfhslearn.com at least every two years – beginning with the 2013-2014 school year.
- d) Each school will be responsible for monitoring the participation of its coaches in the concussion management course, and shall keep a record of those who participate.

I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.

SIGNED:

(Student)

(Parent or Guardian)

DATE:

Receipt Acknowledgement for Athlete / Parent

**Handbook for GHSA Sanctioned Interscholastic Athletic Activities
2013-2014**

Student Name _____ School _____

I understand that I am responsible for reading and understanding the information in the *Athlete/Parent Handbook for GHSA Sanctioned Interscholastic Athletic Activities* (the "handbook"). Parents/guardians are responsible for ensuring their students understand this information.

I understand I am responsible for downloading or accessing a copy of the handbook from the school's website. If I cannot access the handbook, I will ask for a copy from the coach, or the front office of the school.

I understand that this handbook contains required forms, and rules and behavioral expectations for student participants that students are expected to follow at school as well as off campus and in the community. I understand that failure to follow these rules may result in suspension from a team or activity, reduction in participation, and removal from a team or activity, as well as other school sanctions. I understand that participation in extracurricular activities is a privilege, not a right, and student participants are expected to exhibit exemplary behavior and leadership skills at school and in the community, or that privilege will be removed.

I understand that the most up to date GHSA rules and information is available at www.ghsa.net.

I understand and agree that student directory information, as discussed in the Directory Information Statement in the Code of Conduct & Discipline Handbook which I received upon enrollment and each school year, may be released as discussed in the Directory Information Statement for purposes related to GHSA Interscholastic Athletic Activities.

If you disagree with this release, please contact _____ directly, but please note that activity participation may require public performances and public acknowledgement of student and his/her identity.

If I have any questions about information contained in this handbook, I will ask a school administrator or coach to discuss those questions with me. Failure to sign and return this form does not relieve me from complying with and understanding the information enclosed in the handbook.

Parent/Guardian Signature: _____

Date: _____

AND

Student Signature: _____

Date: _____