

GWINNETT COUNTY CONSENT and INSURANCE FORM

If you have completed this form in the past, you will not need to complete again. If we cannot locate a copy of this at NHS, we will ask you complete. Please return this sheet for your records.

Student Name (please print): _____

Parent Signature (please print): _____

Parent Name (please print): _____

Other NHS sports played: _____

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 _____

Gwinnett County Public School athletes will take part in the ImPACT program. ImPACT (Immediate Post-Concussion and Cognitive Testing) is a research-based software tool utilized to evaluate recovery after a concussion. As part of the ImPACT program, GCPS athletes will be required to take a "new" baseline test prior to participation in athletics. ImPACT evaluates multiple aspects of neurocognitive function, including memory, attention, and brain processing speed, reaction time and post-concussion symptoms. It is a 20-minute test battery that will be administered in the pre-season to set a baseline and again post-injury to track a concussion.

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 _____

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EMERGENCY INFORMATION

Allergies _____

Other Information _____

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

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