DEPARTMENT OF ATHLETICS
Middle School Athletic Participation, Insurance, & Consent Form

Please print and use blue or black ink only. Parent/guardian signature required in four (4) places & initials in three (3) places.

Name ____
(Last) (First) (Middle)

Date of Birth (MM/DD/YYYY) ______________________ Male [ ] Female [ ]

Address ____
(Street) (Apt. No) (City, State) (Zip Code)

School ____________________ Grade level for upcoming School Year __________

Known Medical Conditions______________________________________

Known Allergies______________________________________

Medications ______________________________________

Name of Parent/Guardian: ______________________________________

Telephone: Home ______________ Work ______________ Cell/Other ______________

Please give an emergency contact (**<u>must be 21 or older</u>**) and method to contact if the parent/guardian cannot be reached:

Name ______________________ Relationship ______________________

Phone Number:______________________ Alternative Number ______________________

- -

PARENTAL CONSENT FOR ATHLETIC PARTICIPATION

WARNING! : Although participation in supervised inter-scholastic 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 INTER-SCHOLASTIC 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**. Although serious injuries are not common in supervised athletic programs, it is possible only to minimize, not eliminate this risk.

Participants can and have a responsibility to help reduce the chance of injury. **PARTICIPANTS 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/GUARDIANS 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 ______________Middle School of the Bibb County School District in the following sports (please check all that apply):

   [ ]Baseball [ ]Basketball [ ]Cheerleading [ ]Football [ ]Soccer

   [ ]Softball [ ]Track & Field [ ]Weight Training [ ]Wrestling

2) 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.
3) Students found illegally enrolled out of their school attendance zone could be ruled ineligible for competition for one (1) full year.
4) Parents/Guardians should contact the Head Coach for information regarding injuries to their son/daughter.

This acknowledgement of risk and consent to allow participation shall remain in until revoked in writing.

______________________________ ______________
Signature of Parent(s) or Guardian(s) ***Date***

______________________________ ______________
Signature of Student-Athlete ***Date***

(Original Form on file at ______________________ Middle School)

Grade Level ______ Middle Initial ______ First Name ______ Last Name ______

BIBB COUNTY SCHOOL DISTRICT PERMISSION TO PARTICIPATE IN ATHLETIC TEAM ONE-DAY SCHOOL –SPONSORED TRIPS & MEDICAL AUTHORIZATION

Consent
I hereby consent for ____ (student's name) to participate in school-sponsored trips, excluding overnight trips, associated with inter-scholastic competitions. I understand that transportation may or may not be provided by the Bibb County School District. In the event transportation is not provided by the Bibb County School District, transportation will be the student's responsibility. _______**(INITIAL)**

Medical Authorization
In the event of injury or illness during the period of time which the student is participating in a school athletic practice or contest away from his/her legal residence and the school district is ***unable*** to contact the parent/guardian, I grant the Bibb County School District permission and authority to obtain emergency medical care and/or treatment as necessary for the welfare of the student. Treatment may include, but is not limited to first aid, CPR, medical or surgical treatment, or hospitalization. **I, as parent/guardian, accept the financial responsibility for such medical care or treatment**. _______**(INITIAL)**

Waiver
I release and waive, and further agree to indemnify, hold harmless or reimburse the Bibb County School District, the Bibb County Board of Education, its successors and assigns, its members, agents, employees, and representatives thereof, as well as trip supervisor(s), from and against, any claim which I, any other parent or guardian, any sibling, the student, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, from any losses, damages, or injuries arising out of, during, or in connection with the student's participation in the activity, any trip associated with the activity, or the rendering or emergency medical procedures or treatment, if any. _______**(INITIAL)**

Signature of Parent/Guardian ____ **Date** _________________

INSURANCE INFORMATION

The Bibb County School district requires that student-athletes are adequately and currently covered by insurance that will cover injuries sustained while participating in inter-scholastic sports (including, but not limited to, Football). Medicaid may not be honored as an acceptable form of insurance for a student-athlete. Please contact the school for more information. The Bibb County School District does offer a student benefit plan if you wish to purchase additional coverage for your student. If any changes occur in your student's insurance coverage, please notify the coach immediately and provide the new insurance coverage information.

Insurance Company: __________________________________ Address: ____________________________________

Policy Number: ______________________________________ Group Number: ______________________________

Name of Policy Holder: _______________________________ Name of Insured Student:______________________

Signature of Parent/Guardian ____ **Date** _________________

AUTHORIZATION

I understand that per the Georgia State Law a Pre-participation Physical Evaluation must be performed by a physician to medically screen each student who participates in the athletic programs of the Bibb County School District. I further understand that a basic medical screening (the required physical exam) is general in nature and limited in its scope and does not indicate or assure me that my child is completely free from impairments. If I wish for a more detailed exam to be performed upon my child/ward then it is my responsibility to arrange and pay for such an exam. If this more detailed exam is performed, it is my responsibility to notify the Bibb County School District, and its appropriate employees, of any potential medical problems uncovered by any physical exam given to my child/ward other than the general physical exam 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 child/ward, 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 the Bibb County School District, their schools, their trustees, officers, Board members, Board of Education, employees, agents, coaches, athletic trainers, physicians, 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 Bibb County School District or indemnified party arising out of any injuries to my child/ward 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 athletic programs provided by the Bibb County School District.

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

Signature of Parent/Guardian ____ **Date** _________________
Relation to Student (Please check one)
Mother [ ] Father [ ] Guardian [ ] *(Please specify relationship)* ______________________________

RELEASE FOR TREATMENT
AT
PIEDMONT SPORTS MEDICINE

STUDENT INFORMATION

Date: ____________________

Name: ____________________

School: ____________________

Home Address: ____________________

____

SS#: ____________________

School Address: ____________________

Phone: ____________________

Parent/Guardian: ____________________

Address: ____________________

Employer: ____________________

Phone: (H) __________ (W) __________

INSURANCE INFORMATION:

Primary Insurance: ____________________

Address: ____________________

Name of Person who carries insurance: ____________________

Place of employment: ____________________

Address: ____________________

SS#: ____________________

City: ____________________

Secondary Insurance: ____________________

Address: ____________________

Name of Person who carries insurance: ____________________

Place of employment: ____________________

Address: ____________________

SS#: ____________________

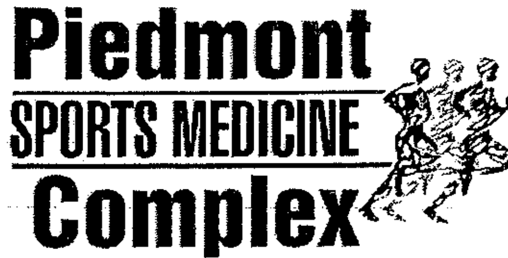
City: ____________________

****

I GIVE PERMISSION FOR THE PHYSICIANS AT PIEDMONT SPORTS MEDICINE TO TREAT MY SON/DAUGHTER ____________________.
(PATIENT'S NAME)

____
Parent's Signature

____
Date



Bill Barnes, M.D.
Steve Barnes, M.D.
Jeffrey Bennett, M.D.
Layne Myers, M.D.
Pamela Onderko, D.P.M.
Paul Peterson, PA

Practice Limited To
Sports Medicine and
Orthopedic Surgery

To: Principals, Coaches, Parents

To Whom It May Concern:

If you are not aware of the present medical situation, most insurance plans are now requiring that policy holders be seen by a primary care physician first, who will direct care to an appropriate specialist, if deemed necessary. In effect, this means that even if your athlete or child has sustained a significant injury, we would not be authorized to perform any type of intervention without approval from the primary care physician. Even with the required primary care giver approval, we are forced to wait for pre-certification from claims representatives before being allowed to prescribe diagnostic testing or performing any type of intervention procedures.

It is our goal to provide the best possible care for your athletes and children. We have a Saturday morning clinic during football season starting at 9:00 am until all athletes are evaluated and treated for injuries that may have occurred during the season. We would like to request participation from primary care practitioners, for evaluation only, in the Saturday morning clinic and will follow up with appropriate medical information to the primary care physician once a potential diagnosis has been made.

We cover several local high school and collegiate teams and it has become increasingly more difficult for us to track which insurance plans an individual participates in. This year when we do our annual pre-season screenings, we will have an insurance form for parents and coaches to provide appropriate insurance information, as well as the primary care physician, for each student. Hopefully, by obtaining the necessary information and putting a process together to deal with this early in the year, it will help circumvent some of the problems we may encounter during the upcoming season. **Each student must complete the insurance information sheet and it must be signed by the parents/guardians before the screenings. If they do not have this sheet completed and signed, Piedmont Sports Medicine Complex will not have the ability to perform the screening for that student athlete.**

We greatly appreciate your support of our endeavors and are happy to be assisting with the management of the athletes for their sports related injuries.

Sincerely,

Mikell Peed, Ph.D., CEO Piedmont Sports Medicine Complex

4660 Riverside Park Boulevard – Macon, GA 31210
478-474-2114 (office) – 478-474-8001 (fax)

PREPARTICIPATION PHYSICAL EVALUATION
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: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ 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: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ 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

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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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■ Preparticipation Physical Evaluation

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex ________ Age ________ Grade ________ School ____________________ Sport(s) ____________________

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	**No**
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

____

____

____

____

____

Please indicate if you have ever had any of the following.

	Yes	**No**
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

____

____

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____

____

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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■ Preparticipation Physical Evaluation
PHYSICAL EXAMINATION FORM

Name ______________________________ Date of birth ______________

PHYSICIAN REMINDERS

1. 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?
2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • 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[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider 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 preparticipation 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

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■ Preparticipation Physical Evaluation
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 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 preparticipation 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 ____

____

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____

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Other information ____

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