

**CLARKE CENTRAL HIGH SCHOOL
CONSENT, INSURANCE, AND ATHLETIC PHYSICAL FORM**

Clarke Central High School
350 South Milledge Avenue
Athens, GA 30605

Phone: (706) 357-5200, 17258 ♦ Fax: (706) 357-5269

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Last Name _____ First Name _____ Middle Initial _____
Age _____ Date of Birth _____ Sex _____ Year Entered Ninth-Grade _____
Address _____ City _____ Zip _____
Phone _____ Email _____
Name of Parent(s) you live with _____

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 Clarke Central High School 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 this form is correct and understand that any false information may result in my son/daughter being declared ineligible.

Signature(s) of parent(s) or guardian(s): _____	Date: _____
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Insurance Information For Athletic Participation

Please INITIAL one of the following statements regarding insurance coverage for you son/daughter for the 2007-2008 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) at Clarke Central High School.

Company provided insurance: _____
Name of insured: _____
Policy #: _____

_____ I understand that I must purchase the appropriate Benefit Plan provided by the Clarke County School System before my child participates in any interscholastic activity at Clarke Central High School. I understand that I must complete the Benefit Plan application and submit the application with payment to the provider for my child to be covered.

Signature(s) of parent(s) or guardian(s): _____	Date: _____
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HISTORY FORM

Pre-Participation Physical Evaluation

Date of Exam _____

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 answer to.**

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Has the doctor ever denied or restricted your participation in sports for any reason? | <input type="checkbox"/> | <input type="checkbox"/> | 24. Do you cough, wheeze, or have difficulty breathing during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have an on going medical condition (like diabetes or asthma)? | <input type="checkbox"/> | <input type="checkbox"/> | 25. Is there anyone in your family who has asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you currently taking any prescription or non prescription (over the counter) medicines or pills? | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have you ever used an inhaler or taken asthma medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have allergies to medicines, pollens, foods, or stinging insects? | <input type="checkbox"/> | <input type="checkbox"/> | 27. Were you born with or are you missing a kidney an eye, a testicle, or any other organ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever passed out or nearly passed out DURING exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 28. Have you had infectious mononucleosis (mono) within the last month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever passed out or nearly passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 29. Do you have a rashes, pressure sores, or other skin problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had discomfort, pain, or pressure in your chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 30. Have you had a herpes skin infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does your heart race or skip beats during exercise? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Have you ever had a head injury or concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has your doctor ever told you that you have | <input type="checkbox"/> | <input type="checkbox"/> | 32. Have you been hit in the head and been confused or lost your memory? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has your doctor ever orders a test for you heart (for example: ECG, echocardiogram) | <input type="checkbox"/> | <input type="checkbox"/> | 33. Have you ever had a seizure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has anyone in your family dies for no apparent reason? | <input type="checkbox"/> | <input type="checkbox"/> | 34. Do you have headaches with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does anyone in your family have a heart problem? | <input type="checkbox"/> | <input type="checkbox"/> | 35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has any family member or relative dies of heart problems or of sudden death before the age of 50? | <input type="checkbox"/> | <input type="checkbox"/> | 36. Have you ever been unable to move your arms or legs after being hit or falling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does anyone in you family have Marfan syndrome? | <input type="checkbox"/> | <input type="checkbox"/> | 37. When exercising in the heat, do you have severe Muscle cramps or become ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever spent the night in a hospital? | <input type="checkbox"/> | <input type="checkbox"/> | 38. Has a doctor told you that you or someone in your family have sickle cell trait or sickle cell disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 39. Have you ever had any problems with you eye or vision? | <input type="checkbox"/> | <input type="checkbox"/> |

17. Have you ever had any injury, like a sprain, muscle or ligament tear or tendonitis that caused you miss a practice or game? If yes, circle affected area below:
18. Have you ever had any broken or fractures bones or dislocated joints? If so circle below:
19. Have you ever had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, crutches? If yes, circle below:

Head	Neck	Shoulder	Upper Arm	Lower Arm	Forearm	Hand/ Finger	Chest
Upper Back	Lower Back	Hip	Thigh	Knee	Calf/ Shin	Ankle	Foot/ Toes

- | | | | | | |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 20. Have you ever has a stress fracture? | <input type="checkbox"/> | <input type="checkbox"/> | 47. Have you ever had a menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you ever been told that you have or have you had an x-ray for atlantoaxial (neck) instability? | <input type="checkbox"/> | <input type="checkbox"/> | 48. How old were you when you had your first menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you regularly use a brace or assistive device? | <input type="checkbox"/> | <input type="checkbox"/> | 49. How many periods have you had in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Has a doctor ever told you that you have asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> | Explain "YES" answers here: _____ | | |

FEMALES ONLY

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 _____ B/P _____ / _____ (____/____, ____/____)
 Vision R20/____ L20/____ Corrected: Y N Pupils: Equal _____ Unequal _____

	Normal	Abnormal Findings	Initials
Medial			
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/ finger			
Hip/ Thigh			
Knee			
Leg/ Ankle			
Foot/ Toes			

* Multiple examiner set-up only
 + Having a third party present is recommended for the genitourinary examination

Notes: _____

- 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**

