

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### 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, e-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-enhancing 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 (Q4–Q13 of History Form).

EXAMINATION		
Height: _____	Weight: _____	
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"> <li>Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li> </ul>	<input type="checkbox"/>	
Eyes, ears, nose, and throat <ul style="list-style-type: none"> <li>Pupils equal</li> <li>Hearing</li> </ul>	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	
Heart <sup>a</sup> <ul style="list-style-type: none"> <li>Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li> </ul>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Skin <ul style="list-style-type: none"> <li>Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis</li> </ul>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder and arm	<input type="checkbox"/>	
Elbow and forearm	<input type="checkbox"/>	
Wrist, hand, and fingers	<input type="checkbox"/>	
Hip and thigh	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Leg and ankle	<input type="checkbox"/>	
Foot and toes	<input type="checkbox"/>	
Functional <ul style="list-style-type: none"> <li>Double-leg squat test, single-leg squat test, and box drop or step drop test</li> </ul>	<input type="checkbox"/>	

<sup>a</sup> Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

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### MEDICAL ELIGIBILITY FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Medically eligible for all sports without restriction

Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

Medically eligible for certain sports

Not medically eligible pending further evaluation

Not medically eligible for any sports

Recommendations: \_\_\_\_\_

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Other information: \_\_\_\_\_

Emergency contacts: \_\_\_\_\_



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### HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

List past and current medical conditions. \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_  
 \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).  
 \_\_\_\_\_  
 \_\_\_\_\_

#### Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box next to appropriate number)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS		
(Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)		
	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has a provider ever denied or restricted your participation in sports for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any ongoing medical issues or recent illness?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOU		
	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has a doctor ever told you that you have any heart problems?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	<input type="checkbox"/>	<input type="checkbox"/>

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)		
	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you ever had a seizure?	<input type="checkbox"/>	<input type="checkbox"/>
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY		
	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	<input type="checkbox"/>	<input type="checkbox"/>





# RELEASE OF LIABILITY FOR MINOR PARTICIPANTS

## READ BEFORE SIGNING

IN CONSIDERATION OF my child/ward being allowed to participate in any way in the Cherokee Christian Schools athletic program and related events and activities, the undersigned acknowledges, appreciates, and agrees that:

The risks of injury and illness (ex: communicable diseases such as MRSA, influenza, etc.) to my child from the activities involved in these programs are significant, including the potential for permanent disability and death, and while particular rules, equipment, and personal discipline may reduce these risks, the risks of serious injury and illness do exist; and,

1. **FOR MYSELF, SPOUSE, AND CHILD, I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS**, both known and unknown, **EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES** or others, and assume full responsibility for my child's participation; and,
2. I willingly agree to comply with the program's stated and customary terms and conditions for participation. If I observe any unusual significant concern in my child's readiness for participation and/or in the program itself, I will remove my child from the participation and bring such attention of the nearest official immediately; and,
3. I myself, my spouse, my child, and on behalf of my/our heirs, assigns, personal representatives and next of kin, **HEREBY RELEASE AND HOLD HARMLESS** Cherokee Christian Schools, Inc., its directors, officers, officials, agents, employees, volunteers, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("Releasees"), **WITH RESPECT TO ANY AND ALL INJURY, ILLNESS, DISABILITY, DEATH**, or loss or damage to person or property incident to my child's involvement or participation in these programs, **WHETHER ARISING FROM THE NEGLIGENCE OF THE RELEASEES OR OTHERWISE**, to the fullest extent permitted by law.
4. I, for myself, my spouse, my child, and on behalf of my/our heirs, assigns, personal representatives and next of kin, **HEREBY INDEMNIFY AND HOLD HARMLESS** all the above Releasees from any and all liabilities incident to my involvement or participation in these programs, **EVEN IF ARISING FROM THEIR NEGLIGENCE**, to the fullest extent permitted by law.
5. I, the parent/guardian, assert that I have explained to my child/ward: the risks of the activity, his/her responsibilities for adhering to the rules and regulations, and that my child/ward understands this agreement.

**I, FOR MYSELF, MY SPOUSE, AND CHILD/WARD, HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT WE HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.**

Name of Child/Ward: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

## **UNDERSTANDING OR RISK**

I understand the seriousness of the risks involved in participating in this program, my personal responsibilities for adhering to rules and regulation, and accept them as a participant.

Name of Child/Ward: \_\_\_\_\_

Signature of Child/Ward: \_\_\_\_\_

Date Signed: \_\_\_\_\_

# Georgia Association of Private & Parochial Schools

Fayetteville, GA 30214

[www.gappschools.com](http://www.gappschools.com)

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(678) 679-7123

## Concussion Information and Acknowledgement Form



Parent and Student:

It is important that parents and students are educated about concussions. All concussions are serious, and concussions can occur in any sport.

1. Definition of Concussion: A brain injury that interferes with the normal brain function.
2. Cause of Concussions: A bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth.
3. Signs and Symptoms of Concussions:

Headache	Slurred Speech	Answers Questions Slowly
Nausea	Moves Clumsily	Sensitivity to Light or Noise
Vomiting	Balance Problems	Unsure of Game, Score or Opponent
Dizziness	Forgets Instruction	Shows Mood, Personality or Behavior Changes
Confused	Numbness/Tingling	Cannot Recall Events
Sluggish	Loses Consciousness	Prior To or After Injury
Fatigue	Concentration Problems	
Blurry Vision	Slowed Thought Process	
Memory Loss	Difficulty Thinking Clearly	
Appears Dazed		
4. In accordance with Georgia Law, the following must occur if an individual exhibits signs, symptoms or behaviors of a concussion:
  - a. The individual shall be immediately removed from practice or competition.
  - b. The individual suspected of having a concussion shall be seen by an appropriate health care professional before the individual can return to athletic participation.
  - c. The individual shall not return to practice or competition the same day the concussion or suspected concussion occurred.
  - d. If no concussion has occurred, the individual can return immediately to practice or competition
  - e. If a concussion has occurred, the individual cannot return to participation in practice or competition until medically cleared by an appropriate health care professional.
  - f. An individual could never return to participation if the individual still has any symptoms of a concussion.
  - g. After clearance has been issued, the individual's actual return to participation in practice and competition should follow a gradual procedure suggested by the National Federation of High Schools and directed by the appropriate health care provider clearing the athlete for activity.
  - h. An appropriate health care profession may include licensed doctor or another licensed individual under the supervision of a licensed doctor such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.
5. The following information can be found online and is recommended for parents and students to read concerning concussions:
  - a. NFHS Suggested Guidelines for Management of Concussion in Sports.
  - b. NFHS, A Parent's Guide to Concussions in Sports
6. Parent and student should sign the form below. The school and parent should maintain a copy of this form.

I have read this form and I understand the facts presented in it.

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Parent/Guardian Printed Name

Student Printed Name

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Parent/Guardian Signature

Student Signature

Date