

FORSYTH COUNTY PHYSICAL FORM

2023– 2024



PINEY GROVE MIDDLE SCHOOL

Student's Last Name

First Name

For Official Use Only:

Verified by: _____

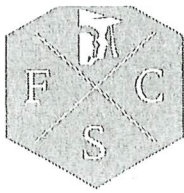
Expiration Date: _____

Put a ✓ if form has been completed

- ☐ FCS Athletic Participation Form
 - ☐ Insurance
 - ☐ No Insurance
- ☐ "Blanket" Permission / Transportation Waiver Forms
- ☐ GHSA Concussion Awareness Form
- ☐ GHSA Sudden Cardiac Arrest Awareness Form
- ☐ History Form
- ☐ Physical Examination Form
- ☐ Medical Eligibility Form
 - ☐ Medically eligible for all sports without restriction
 - ☐ Not medically eligible for any sports
 - ☐ Other: _____

If no insurance, has policy been purchased through the school?

- ☐ Yes
- ☐ No
- ☐ Waiver signed



Forsyth County Physical Form

EXPIRES: _____
OFFICE USE ONLY

FORSYTH COUNTY SCHOOL SYSTEM ATHLETIC PARTICIPATION FORM

FORSYTH COUNTY ATHLETICS		PERMISSION FORM		
Student – Athlete: (Please Print)		Name of Parent/Guardian: (Please Print)		
Street Address:		School:	Grade: CIRCLE ONE 7 8 9 10 11 12	
City:	State:	Zip:	Date of Birth: Phone: Home – Work –	
In the event of emergency, please give the best person and method to contact in the box provided.				
Name:	Relationship:	Phone #:	Alt #:	
Request for Permission: We, the undersigned student and the student's parent/guardian, apply for permission to participate in interscholastic athletics in the following sport(s):				
☐ Baseball / Softball	☐ Cross Country	☐ Lacrosse	☐ Tennis	☐ Gymnastics
☐ Basketball	☐ Football	☐ Soccer	☐ Track & Field	☐ Other: _____
☐ Cheerleading	☐ Golf	☐ Swimming	☐ Wrestling	
General Requirements- We have read and discussed the general requirements for athletic eligibility. We understand that additional questions or specific circumstances should be directed to our student's coach, athletic director or principal. We understand that the FC Athletic Guidelines are available through the county website for review.				
Risk of Injury- We acknowledge and understand that there is a risk of injury involved in athletic participation. We understand that the student-athlete will be under the supervision and direction of a FCSS athletic coach. We agree to follow the rules of the sport and the instructions of the coach in order to reduce the risk of injury to the student and other athletes. However, we acknowledge and understand that neither the coach nor FCSS can eliminate the risk of injury in sports. Injuries may and do occur. Sports injuries can be severe and in some cases may result in permanent disability or even death. We freely, knowingly, and willfully accept and assume the risk of injury that might occur from participation in athletics.				
Release- In consideration of FCSS allowing the student-athlete to participate in athletics, we agree to release and hold FCSS, its athletic coaches and other employees free, harmless and indemnified from and against any and all claims, suits or causes of action arising from or out of any injury that the student-athlete may suffer from participation in athletics.				
Insurance- FCS requires parents to provide information pertaining to medical insurance coverage for all student athletes. Parents have the option to purchase school insurance (please see school athletic director) or to maintain coverage under parental insurance provider.				
Check One: ☐ School Accident Insurance ☐ Name of Other Insurance Company			Policy No.	
Address:			Group No.	
CERTIFICATION AND MEDICAL AUTHORIZATION. We certify that all of the information provided by us on this form is correct. We agree to abide by state and local rules. If the student-athlete is injured while participating in athletics and FCSS is unable to contact the parent, we grant FCSS permission and authority to obtain necessary medical care and/or treatment for the student's injury. Treatment may include, but is not limited to first aid, CPR, medical or surgical treatment recommended by a physician. We accept the financial responsibility for such medical care or treatment.				
We, the undersigned student and parent, have read this document and understand all of the expectations for athletic participation at my school.				
Student:			Date:	
Parent/Guardian Signature:			Date:	

“BLANKET” PERMISSION TO PARTICIPATE IN A SERIES OF SCHOOL SPONSORED FIELD TRIPS

Sport: _____ School Year: _____ School: _____

I hereby request that _____ (Student's Name-PLEASE PRINT); be allowed to participate in athletic team, band, orchestra, chorus, and/or any series of field trips related to one particular area of study or activity. I understand that transportation may or may not be provided by the Forsyth County School District (District). In the event transportation is not provided by the District, transportation will be the parent's responsibility.

All team members will ride to an event in school provided transportation with the team. Any athlete who arranges independent transportation to an event, without permission from the coach and the Athletic Director in advance, will be ineligible to compete in that event. All team members will return to their High School in the Forsyth County provided transportation unless a Travel Release form is completed by a parent/guardian (see the head coach). Athletes will only be released to their own parent/guardian from a contest. A parent/guardian must sign out the athlete from the coach at the contest site. If a student and his/her parent makes arrangements for private transportation, they shall not hold the local school, officers, employees or agents responsible for any injury or loss.

Detailed trip information, including destination, date, time of departure, time of return, purpose, and supervision, will be given to the parents/guardians prior to each trip in the series. (Exceptions must be approved by the School Director of Athletics and Principal).

If any emergency medical procedures or treatment are required by the student during the trip, I consent to the trip supervisor(s) taking, arranging for, and consenting to the procedures or treatment in his/her or their discretion.

In consideration of FCSS allowing the student-athlete to participate in athletics, we agree to release and hold FCSS, its athletics coaches and other employees free, harmless, and indemnified from and against any and all claims, suits or causes of action arising from or out of any injury that the student-athlete may suffer from participation in athletics.

NOTE: This form must be signed by student if the student is 18 years of age or older.

Name of Student (PLEASE PRINT)

Signature of Student (if 18)

Date

Name of Parent/Guardian (PLEASE PRINT)

Signature of Parent/Guardian

Date

TRANSPORTATION WAIVER

THIS SECTION MUST BE COMPLETED BY THE PARENT

NAME OF STUDENT LISTED ABOVE

All team members will ride to an event in school provided transportation with the team. Any athlete who arranges independent transportation to an event, without permission from the coach and the Athletic Director in advance, will be ineligible to compete in that event. All team members will return to their High School in the Forsyth County provided transportation unless a travel release form is completed by a parent/guardian. Athletes will only be released to their own parent/guardian from a contest. A parent/guardian must sign out the athlete from the coach at the contest site. If a student and his/her parent makes arrangements for private transportation, they shall not hold the local school, officers, employees or agents responsible for any injury or loss.

TRAVEL RELEASE FORM – I give my son/daughter permission to ride with an adult chaperone to/from an activity of Forsyth County Schools during the school year. I further understand that I am releasing the school & its staff from my responsibility for any accident that might occur. I also give permission for medical treatment should it be needed.

PARENT / GUARDIAN SIGNATURE

DATE

Georgia High School Association

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.

By signing this concussion form, I give _____ High School permission to transfer this concussion form to the other sports that my child may play. I am aware of the dangers of concussion and this signed concussion form will represent myself and my child during the 2020-2021 school year. This form will be stored with the athletic physical form and other accompanying forms required by the _____ School System.

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

Student Name (Printed)

Student Name (Signed)

Date

Parent Name (Printed)

Parent Name (Signed)

Date

Georgia High School Association

Student/Parent Sudden Cardiac Arrest Awareness Form

SCHOOL: _____

1: Learn the Early Warning Signs

If you or your child has had one or more of these signs, see your primary care physician:

- Fainting suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones
- Unusual chest pain or shortness of breath during exercise
- Family members who had sudden, unexplained and unexpected death before age 50
- Family members who have been diagnosed with a condition that can cause sudden cardiac death, such as hypertrophic cardiomyopathy (HCM) or Long QT syndrome
- A seizure suddenly and without warning, especially during exercise or in response to loud sounds like doorbells, alarm clocks or ringing phones

2: Learn to Recognize Sudden Cardiac Arrest

If you see someone collapse, assume he has experienced sudden cardiac arrest and respond quickly. This victim will be unresponsive, gasping or not breathing normally, and may have some jerking (Seizure like activity). Send for help and start CPR. You cannot hurt him.

3: Learn Hands-Only CPR

Effective CPR saves lives by circulating blood to the brain and other vital organs until rescue teams arrive. It is one of the most important life skills you can learn – and it's easier than ever.

- Call 911 (or ask bystanders to call 911 and get an AED)
- Push hard and fast in the center of the chest. Kneel at the victim's side, place your hands on the lower half of the breastbone, one on top of the other, elbows straight and locked. Push down 2 inches, then up 2 inches, at a rate of 100 times/minute, to the beat of the song "Stayin' Alive."
- If an Automated External Defibrillator (AED) is available, open it and follow the voice prompts. It will lead you step-by-step through the process, and will never shock a victim that does not need a shock.

By signing this sudden cardiac arrest form, I give _____ *High School* permission to transfer this sudden cardiac arrest form to the other sports that my child may play. I am aware of the dangers of sudden cardiac arrest and this signed sudden cardiac arrest form will represent myself and my child during the 2020-2021 school year. This form will be stored with the athletic physical form and other accompanying form required by the _____ School System.

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

Student Name (Printed)

Student Name (Signed)

Date

Parent Name (Printed)

Parent Name (Signed)

Date

(Revised: 2/20)

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

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

Name: _____ Date of birth: _____
(First Name) (Last Name)

Date of examination: _____ Sport(s): _____

Sex assigned at birth: _____

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	☐ 0	☐ 1	☐ 2	☐ 3
Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3

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

(First Name)

(Last Name)

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?	☐	☐	☐
2. Has a provider ever denied or restricted your participation in sports for any reason?	☐	☐	☐
3. Do you have any ongoing medical issues or recent illness?	☐	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU		Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?	☐	☐	☐
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐	☐
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	☐	☐	☐
7. Has a doctor ever told you that you have any heart problems?	☐	☐	☐
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	☐	☐	☐

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	☐	☐
10. Have you ever had a seizure?	☐	☐
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)?	☐	☐
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)?	☐	☐
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	☐	☐

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____
(First Name) (Last Name)

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: ☐ Y ☐ N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	☐	
Eyes, ears, nose, and throat - Pupils equal - Hearing	☐	
Lymph nodes	☐	
Heart ^a Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	☐	
Lungs	☐	
Abdomen	☐	
Skin Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis	☐	
Neurological	☐	
MUSCULOSKELETAL	NORMAL	ABNORMAL FINDINGS
Neck	☐	
Back	☐	
Shoulder and arm	☐	
Elbow and forearm	☐	
Wrist, hand, and fingers	☐	
Hip and thigh	☐	
Knee	☐	
Leg and ankle	☐	
Foot and toes	☐	
Functional Double-leg squat test, single-leg squat test, and box drop or step drop test	☐	

^a 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

■ PREPARTICIPATION PHYSICAL EVALUATION

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: _____



Piney Grove Middle School Sports Medicine Emergency Information

Name: _____ Current Grade: _____ Birthday: _____

Drug Allergies/Medications/Medical Problems: _____

Parent(s)/Guardian(s): _____

Email Address: _____

Home Address: _____

Home Phone: _____ Parent/Guardian Phone: _____

Person to Contact in an Emergency: _____

Phone: _____ Alternate Phone: _____

Is the Athlete Listed Above Covered by Private Medical Insurance? Yes No

Insurance Company: _____

Policy Holder's Name: _____

Policy Number: _____ Group Number: _____

**I/We give my/our permission to the PGMS coaching staff to seek emergency medical care for my/our child in my/our absence.*

Parent(s)/Guardian(s) Signature: _____ Date: _____

Comments/Notes: _____

