Tiftarea Academy

P.O. Box 10
3144 Highway 41 North
Chula, Georgia 31733
(229) 382-0436 • Fax (229) 382-7742

Mr. Stacey Bell, Ed. S.
Headmaster

Larry Creamer, Ph. D.
Counselor/Assistant Headmaster

Chance Benson, M. Ed.
Upper School Principal

Debbie Young, M. Ed.
Lower School Principal

James W. (Kip) Stevens, Ed. D.
Athletic Director

ATHLETE AGREEMENT AND PARENT/GUARDIAN FORM

SPORTS: Check all sports you will be participating in this year.

Fall	**Winter**	**Spring**
___ Cheerleading	___Basketball	___Baseball
___ Cross Country	___Cheerleading	___Golf
___ Football	___Swimming	___Soccer
___ Shot Gun	___Wrestling	___Tennis
___ Softball	___ Fishing Team	___Track

Name _____ Date_____

This agreement to compete in interscholastic athletics is entirely voluntary on my part. I am aware that playing or practicing in athletics can be dangerous in nature involving **MANY RISK OF INJURY.**

Because of the dangers of participating in the above listed sports, I recognize the importance of following the coach's instructions regarding techniques, training, and team rules and herby agree to obey such rules.

In consideration of the Tiftarea Academy Athletic Department permitting me to try out for the teams checked and engage in all activities related to the team including, but not limited to, trying out, practicing or participating in that sport, I hereby assume all the risks associated with participation and agree to hold the Tiftarea Academy Board, its Athletic Department, its employees, agents, representatives, coaches, and volunteers harmless from any and all liability, actions, debts, claims, or demands of any kind and nature whatsoever which may arise by or connection with my participation in any activities related to the sports checked above. The terms hereof shall serve as a release and assumption of risk for my heirs, estate, executory, administrator, and for all members of my family.

I will adhere to the rules and regulations set for by the Georgia Independent Schools Association (GISA), Tiftarea Academy and its Board, and the Tiftarea Academy Athletic Department. This will also include if I quit a sport before the season is finished, I will not be allowed to participate in another sport until the season is over of the sport I quit. Furthermore, I understand that I will be held responsible for athletic equipment issued to me. I recognize that it is a privilege to compete in athletics and will strive to earn respect for myself, family, school, and community.

My parents/guardians will respect the 24 hour rule of talking to coaches/administrators concerning a game.

My parents/guardians will also agree to work in the concession stand during my season for at least 2 games or pay a participation fee of $100 per season.

_____ _____
Signature of Parent Date

_____ _____
Signature of Athlete Date

COMMITTED TO EXCELLENCE

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Emergency Treatment and Parent Consent Form

Name: _____ **GRADE**_____ **BIRTHDATE**_____ **AGE**_____

PRIMARY PARENT(s)/GUARDIAN(s) _____

ADDRESS_____ **CITY**_____ **STATE** ____ **ZIPCODE**_____

PARENT/GUARDIAN #1 Name/Cell # _____

PARENT/GUARDIAN #2 Name/Cell # _____

In an emergency if the parents/guardians CANNOT be reached, please call:

Name/Relationship: _____ **PHONE**_____

Family Physician:_____ **PHONE**_____

Known allergies: _____

Permission is hereby given to the attending physician to proceed with any medical or minor surgical treatment, x-ray, examination and immunizations for the above named athlete. In the event of an emergency arising out of a serious illness or injury, the need for major surgery, or significant accidental injury, I understand an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is NOT able to communicate with me, the treatment necessary for the best interest of the above-named student may be given.

_____ _____

Parent/Guardian Signature **Date**

Insurance Waiver (SELECT ONE)

____ I hereby certify that I have health/accidental insurance for my child, _____.
I **WILL NOT** hold Tiftarea Academy administration or coaching staff liable in any way for injuries to my child because of athletic participation. I realize that participation in organized school athletics involves the potential for injury.

_____ _____

Insurance Company Policy Number

____I will allow my child, _____, to participate in the Tiftarea Academy Athletic Department and I do not have insurance. **I will take care of any medical bills incurred by my child as a result of their participation in Tiftarea Academy Athletics.** I realize that Tiftarea Academy as well as the administration and coaching staff **WILL NOT** be responsible for medical bills resulting from an accident while my child is participating in a sport.

_____ _____

Parent/Guardian Signature Date

COMMITTED TO EXCELLENCE

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: _____

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	☐ 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.)

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?	☐	☐

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	☐	☐
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	☐	☐
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐	☐
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	☐	☐
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?	☐	☐
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	☐	☐
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	☐	☐
22. Have you ever become ill while exercising in the heat?	☐	☐
23. Do you or does someone in your family have sickle cell trait or disease?	☐	☐
24. Have you ever had or do you have any problems with your eyes or vision?	☐	☐

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?	☐	☐
26. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
27. Are you on a special diet or do you avoid certain types of foods or food groups?	☐	☐
28. Have you ever had an eating disorder?	☐	☐
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?	☐	☐
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or 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, 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?
2. 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 *Staphylococcus aureus* (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

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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: _____

_____

_____

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Tiftarea Academy
Student/Parent Concussion Awareness Form

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.

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.)

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 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 Tiftarea Academy 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 2021-2022 school year. This form will be stored with the athletic physical form and other accompanying forms required by Tiftarea Academy.

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

Tiftarea Academy

Student/Parent Sudden Cardiac Arrest Awareness Form

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 10 times/minute, to the beat of the song "Staying' 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 Tiftarea Academy 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 2021-2022 school year. This form will be stored with the athletic physical form and other accompanying forms required by Tiftarea Academy.

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

TIFT REGIONAL
MEDICAL CENTER
901 E. 18th street, Tifton, GA 31794 0229-382-7120 or 800-648-1935
www.tiftregional.com

ATHLETIC TRAINER SERVICES CONSENT FORM

Tift Regional Medical Center ("TRMC") has agreed with Tiftarea Academy to provide athletic training services for certain sports at Tiftarea Academy (TA), including the sport(s) participated in by the student athlete named below. The athletic training services will be provided by a certified athletic trainer, and not a physician or other type of health care professional.

The athletic training services which may be provided by TRMCs certified athletic trainer include, but are not limited to: performing assessments of student athletes, administering first aid for athletic injuries, providing initial treatment and management of acute injuries, assessing athletic injuries, and recommending appropriate follow-up care and treatment to the student athlete and/or his/her parent or guardian. TRMC's certified athletic trainer will perform only those procedures, services and assessments which are within the trainer's training, experience, credential limitations and scope of professional practice.

The student athlete and/or his/her parent(s) or guardian(s) are responsible for obtaining any follow-up care and treatment which may be necessary to address injuries sustained while participating in TA athletic events.

Under the agreement between Tiftarea Academy and TRMC, the certified athletic trainer is not required to be on-site for each and every athletic event or practice, and therefore, there is no guarantee the certified athletic trainer will always be on-site and available if the student athlete is injured.

In furtherance of the student athlete's medical care and treatment, the certified athletic trainer and other TRMC staff shall be authorized to disclose information concerning the student athlete's injury(ies) and treatment to the student athlete's other health care providers, coaches and instructors, and parent(s) or guardian(s).

In addition to the athletic training services described above, under the agreement between TRMC and Tiftarea Academy, TRMC has agreed to offer annual physicals for eligible TA student athletes.

Having read and understood the above provisions, I hereby acknowledge and agree to be bound by such provisions and hereby give my express permission and consent for the student athlete listed below to receive athletic training and other services from TRMC.

***This consent shall remain valid for the entire school year and shall apply for each TA sport in which the student athlete participates.

Name of student athlete: _____

***This consent form may be executed by the student athlete if he/she is at least eighteen (18) years of age.

Student Athlete Signature (if 18 or older): _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Print name of Parent/Guardian: _____