Important Information about
Tiftarea Academy's 2023-24 Sports Physicals

ALL eleven forms MUST be completed and returned before your son/daughter may try-out and/or begin practice for any athletic program at Tiftarea Academy.

If you want your child to receive a free sports physical on Saturday, April 22nd between 9:45-11 please return the packet with 10 of the forms completed with parent and student's signatures by Thursday, April 20th. Returning your form on time will guarantee your child a spot on the day of physicals. Physicals are only available for students in grades 6-12 during the 2023-24 School year. Younger athletes must see their regular health provider. If you are not participating in the free physical program please return your child's completed physical by 5/4/23.

Sports Physicals are April 22nd 8:30-12:00; however, Tiftarea students have been given a priority time between 9:45 -11. Georgia Sports Medicine MSK Building 2227 US Highway 41 North.

The physicians will sign off on the Physical Examination Form and the Medical Eligibility Form. Physicians have to have the history form completed and signed by a parent/guardian before they will examine your child.

EVERY form contains information that is REQUIRED by the GIAA to be kept on file. Failure to complete ALL forms will result in your son/daughter not being able to participate until the completed forms are returned to the Athletic Director for the sport.

Please make a copy of all forms to keep with your important papers at home. Several summer camp programs require these same forms.

Each physical expires 365 days from the date on which it was completed. GIAA policy states that any physical completed after April 1 of each year will suffice to the end of the next school year.

_____ Athletic Agreement Form:	Signatures from Parent & Athlete
_____ Emergency Treatment Form:	Two Signatures from Parent
_____ History Form 1:	Student must complete Patient Health Section
_____ History Form 2:	Signatures from Parent & Athlete
_____ Physical Examination Form:	Please fill in Name and Date of Birth
_____ Medical Eligibility Form:	Please fill in Name, Date of Birth & Shared Emergency Info
_____ Concussion Awareness Form:	Signatures from Parent & Athlete
_____ Heat Policy Agreement Form:	Signatures from Parent & Athlete
_____ Cardiac Arrest Awareness Form:	Signatures from Parent & Athlete
_____ Athletic Trainer Service Form:	Signatures from Parent & Athlete
_____ AT Medication Dist Form:	Signatures from Parent & Athlete

Tiftarea Academy
P. O. Box 10
3144 Highway 41 North
Chula, GA 31733
229-382-0436 Fax 229-382-7742

ATHLETE AGREEMENT AND PARENT/GUARDIAN FORM

SPORT: Check all sports 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 Athletic Association (GIAA), Tiftarea Academy and its Board, and the Tiftarea Academy Athletic Department. 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 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

Tiftarea Academy
P. O. Box 10
3144 Highway 41 North
Chula, Ga 31733
229-382-0436 Fax 229-382-7742

Emergency Treatment and Parent Consent Form

NAME _____ **GRADE 23-24** _____

BIRTHDATE_____ **AGE**_____

PARENTS/GUARDIANS_____**PHONE**_____

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

PARENTS/GUARDIANS CELL NUMBER_____

PARENTS/GUARDIANS CELL NUMBER_____

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**

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 at Time of Birth (Male or Female): _____

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: _____

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

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: _____

_____

_____

_____

GEORGIA INDEPENDENT ATHLETIC ASSOCIATION

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.

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 GIAA 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.)

GIAA Concussion Policy: If a Coach observes a Student-Athlete exhibit any sign, symptom, or behavior consistent with a concussion or head injury, the Coach must immediately remove that Student-Athlete from practice, conditioning, or game. The Student-Athlete may not return to practice, conditioning, or game until a Health Care Provider has determined that the Student-Athlete has not suffered a concussion. In the case where a Health Care Provider has determined that the Student-Athlete has suffered a concussion, the Student-Athlete may not resume practice, conditioning, or participation in games until medically determined capable of doing so for full or graduated return. In no circumstance may a Student-Athlete return to practice, conditioning, or a game on the same day that a concussion has been diagnosed by a Health Care Provider or cannot be ruled out

By signing this Concussion Awareness Form, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of concussions and this signed Form will represent myself and this child during the current school year _____. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).

WE HAVE READ THIS FORM AND UNDERSTAND THE FACTS REPRESENTED IN IT.

SCHOOL NAME:_____

STUDENT'S NAME:_____ STUDENT'S SIGNATURE:_____
(PRINTED)

PARENT'S NAME:_____ PARENT'S SIGNATURE:_____
(PRINTED)

DATE SIGNED:_____

GEORGIA INDEPENDENT ATHLETIC ASSOCIATION

HEAT POLICY AWARENESS FORM

Definitions:

A. **"Practice"** means the period of time that a student engages in coach-supervised, school-approved preparation for sport whether indoors or outdoors, including Acclimation Activities, conditioning, weight training, distance running, and scrimmages, but not including a Walk Through.

B. **"Walk Through"** means the period of time, not exceeding one hour per day, that a student engages in coach-supervised, school-approved sessions, whether indoors or outdoors, to work on formations, schemes, and techniques without physical contact. No protective equipment is worn during a Walk Through. No conditioning activities are held during a Walk Through. A Walk Through may not be held on a day when two practices are being held.

C. **"Acclimation Activities"** in football means practicing in shorts, shoulder pads, and helmets for five consecutive weekdays prior to practicing in full pads. No contact will be allowed during this period. Starting Date for Acclimation is July 25.

D. **"WBGT"** stands for the Wet Bulb Globe Temperature reading, which is a composite temperature used to estimate the effect of air temperature, humidity, and solar radiation on the human body, expressed in degrees. It is not equated with the "Heat Index."

Policy: All Member Schools will utilize at each Practice a scientifically approved instrument that measures WBGT. At the following WBGT readings the corresponding activity, hydration, and rest break guidelines apply:

Under 82.0
Normal activities. Provide at least three separate rest breaks each hour of a minimum duration of 3 minutes each during Practice.

82.0 - 86.9
Use discretion for intense or prolonged exercise. Watch at-risk students carefully. Provide at least three separate rest breaks each hour of a minimum of four-minute duration each during Practice.

87.0 - 89.9
Maximum outdoor Practice time is two hours. For football, students are restricted to helmets, shoulder pads, and shorts during Practice. All protective equipment must be removed for conditioning activities. For all sports, provide at least four separate rest breaks each hour of a minimum of four minutes each during Practice.

90.0 - 92.0
Maximum outdoor Practice time is one hour. No protective equipment may be worn during outdoor Practice and there may be no outdoor conditioning activities. There must be twenty minutes of rest breaks provided during the hour of outdoor Practice.

Over 92
No outdoor activities or exercise. Delay outdoor Practice until a lower WBGT reading occurs.

The following guidelines apply to **hydration and rest breaks**:

- Rest time should involve both unlimited hydrations (water or electrolyte drinks) and rest without any activity involved.
- For football, helmets should be removed during rest time.
- The site of the rest time should be a cooling zone not in direct sunlight, such as indoors, under a tent, or under a shade tree.
- When the WBGT is over 86, ice towels and spray bottles filled with ice water should be available in the cooling zone and cold immersion tubs will be available for a student showing signs of heat illness. A cold immersion tub may be anything, including a shower or wading pool that can be adapted to immerse a student in cold water and ice which is available within two-minutes travel from an outdoor Practice facility.

The following guidelines apply to **Practice**:

- All Member Schools must hold Acclimation Activities.
- No two-a-day Practices may exceed four hours for both sessions; no single Practice during two-a-days may exceed two hours. A three-hour rest period must be observed between the two sessions.
- No single Practice may last more than three hours.

Restrictions based on outdoor WBGT readings do not apply to indoor Practice where indoor air temperature is 85 degrees or less.

Penalties
Member Schools violating this policy will be fined a minimum of $500 and a maximum of $1,000 for the first offense. A Member School may be removed from membership for repeat violations.

By signing this Heat Policy Form, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of heat and this signed Form will represent myself and this child during the current school year _____. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).

SCHOOL:_____

ATHLETIC DIRECTOR'S SIGNATURE:_____ DATE:_____

STUDENT ATHLETE'S SIGNATURE:_____ DATE:_____

PARENT'S SIGNATURE:_____ DATE:_____

GEORGIA INDEPENDENT ATHLETIC ASSOCIATION

STUDENT / PARENT SUDDEN CARDIAC ARREST AWARENESS FORM

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.

LEARN TO RECOGNIZE SUDDEN CARDIAC ARREST

If you see someone collapse, assume they have 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). Call for help and start CPR. You cannot hurt them.

LEARN HANDS-ON 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 is 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, we give permission to the school to transfer this Form to all sports that this child may play. We are aware of the dangers of sudden cardiac arrest and this signed Sudden Cardiac Arrest Form will represent myself and this child during the current school year _____. This form will be stored with the Athlete's Physical Form and any other accompanying forms required by the Georgia Independent Athletic Association (GIAA).

WE HAVE READ THIS FORM AND UNDERSTAND THE FACTS REPRESENTED IN IT.

SCHOOL NAME:_____

STUDENT'S NAME:_____ STUDENT'S SIGNATURE:_____
(PRINTED)

PARENT'S NAME:_____ PARENT'S SIGNATURE:_____
(PRINTED)

DATE SIGNED:_____

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: _____

Tiftarea Academy Athletic Trainer Medication Distribution Form

By signing this form, you are allowing Tiftarea Academy Athletic Trainer Claire McQuaig, LAT, ATC to distribute over the counter medications to your child and/or athlete. A list of the possible medications that could be given to your child/athlete are listed below. If your child has an allergy to any of the listed medications, please specify which medications your child should not receive in the space provided below.

This process is reliant on the honesty of the child/athlete when being asked questions about their symptoms and needs for the medication. It is also important that the athlete is honest about the amount of medications they have taken prior to coming to the athletic trainer for additional medication.

By the child/athlete signing this document he/she is claiming responsibility of honesty to the athletic trainer about the concerns discussed above. Signing this form means that no contact is required from the athletic trainer to the parent for approval of distribution of medication to their child.

List of medications:

Ibuprofen
Tylenol
Antacids
Triple antibiotic ointment

☐ By checking this box, I am giving Tiftarea Academy Athletic Trainer Claire McQuaig, LAT, ATC permission to distribute over the counter medications to my child/athlete.

☐ By checking this box, I am **NOT** giving Tiftarea Academy Athletic Trainer Claire McQuaig, LAT, ATC permission to distribute over the counter medications to my child/athlete.

Parent name (Print): _____ Parent Signature: _____

Athlete name (Print): _____ Athlete Signature: _____

Medication Comments Below: