Parent/Guardian of Athlete,

Physicals for all sports for the 2018-2019 school year will be provided by medical personnel from Tift Regional Health System. Physicals will take place on **Saturday, May 5th from 9:30 – 11 am** at Tift Regional's Outpatient Physical Therapy clinic located at 1641 Madison Ave. in Tifton, near the hospital off Old Ocilla Rd. Students will be assigned a date and time based upon their age and sport.

Physicals preformed on May 5th are FREE for all participating athletes. If you do not have transportation available to be at Outpatient Physical Therapy during your assigned time, please get with your coach to make arrangements.

Attached are several forms that **you MUST fill out** and have your student return to the front office by **Tuesday, May 1st**. **If these forms are incomplete – the student will not receive a free physical – they must be completed and signed by a parent/guardian.**

1. Athletic Agreement & Parent/Guardian Form – REQUIRES a parent/guardian and student signature
2. Emergency Treatment and Parent Consent Form – REQUIRES a parent/guardian signature
3. GISA History Form – REQUIRES a parent/guardian signature & student signature
4. GISA Supplemental History Form IF your athlete has special needs. REQUIRES a parent/guardian **IF** form applies to your athlete & athlete signature – PLEASE REVIEW ENTIRE FORM mark as N/A if needed.
5. Physical Exam Form – Signed by physician
6. Clearance Form – Signed by physician
7. Athletic Trainer Services Consent Form – REQUIRES a parent signature
8. Concussion Information Form – REQUIRES student AND parent signature
9. Worksmart/TRMC Consent for on-site screenings – REQUIRES parent signature

PLEASE MAKE SURE ALL SECTIONS ARE COMPLETED AND ALL DOCUMENTS ARE SIGNED WHERE INDICATED AND RETURNED BY TUESDAY, MAY 1ST

All students participating in Junior Pro sports must have their physical completed by their primary physician. Physicals must be on file PRIOR to a student participating in any organized practices.

WorkSmart Services will preform required physicals for Junior Varsity and Varsity Athletes at their Union Road location for $30 if you can not make the free physical day. Appointments are preferred but can normally see patients if signed in by 4pm.

Quick Care on Hwy 82 will preform required physicals for all students for $30. No appointment necessary they are open 8-7 M-F and 8-5 on Saturday.

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

Michael Heitzman, M.Ed.
Upper School Principal

Debbie Young, M.Ed.
Lower School Principal

Tim Hathcock, M.Ed.
Athletic Director

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		___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 hereby 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, executor, 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. 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/Guardian Date

_______________________________ _______________________

Signature of Athlete Date

Tiftarea Academy

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EMERGENCY TREATMENT AND PARENT CONSENT FORM

NAME______________________________GRADE________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____PHONE_______________________________________

FAMILY DOCTOR____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: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam ____________________

Name ____________________ Date of birth ____________________

Sex ______ Age ______ Grade ______ School ____________________ Sport(s) ____________________

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

____

____

____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: ____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: ____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

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

Signature of athlete ____________________ Signature of parent/guardian ____________________ Date ______

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PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam ______________________________

Name ______________________________ Date of birth ______________

Sex ______ Age ______ Grade ______ School ______________ Sport(s) ______________

1. Type of disability		
2. Date of disability		
3. Classification (if available)		
4. Cause of disability (birth, disease, accident/trauma, other)		
5. List the sports you are interested in playing		
	Yes	**No**
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

____

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____

____

____

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

____

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

Signature of athlete ______________ Signature of parent/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, 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 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 (questions 5–14).

EXAMINATION		
Height Weight ☐ Male ☐ Female		
BP / (/) Pulse Vision R 20/ L 20/ Corrected ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________

☐ Not cleared

☐ Pending further evaluation

☐ For any sports

☐ For certain sports ______________________

Reason ______________________

Recommendations ______________________

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ______________________ Date __________

Address ______________________ Phone __________

Signature of physician ______________________, MD or DO

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PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name ______________________ Sex ☐ M ☐ F Age __________ Date of birth __________

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for ______________________

____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports ______________________
  - Reason ______________________

Recommendations ______________________

____

____

____

____

____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) ______________________ Date __________

Address ______________________ Phone __________

Signature of physician ______________________, MD or DO

EMERGENCY INFORMATION

Allergies ______________________

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____

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Other information ______________________

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901 E. 18th Street, Tifton, GA 31794 • 229-382-7120 or 800-648-1935
www.tiftregional.com

ATHLETIC TRAINER SERVICES CONSENT FORM

Tift Regional Medical Center ("TRMC") has agreed with the Tift County School District to provide athletic training services for certain sports at Tift County High School ("TCHS"), 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 TRMC's 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 TCHS athletic events.

Under the agreement between the Tift County School District 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 the Tift County School District, TRMC has agreed to offer annual physicals for eligible TCHS 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 TCHS 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: ______________________________

APPENDIX A
CONCUSSION INFORMATION FOR STUDENT ATHLETES

NAME OF SCHOOL:____

According to the article "Concussion" by the Mayo Clinic Staff,[1] a concussion is defined and has symptoms as follows:

Definition:
A concussion is a traumatic brain injury that alters the way your brain functions. Effects are usually temporary, but can include problems with headache, concentration, memory, judgment balance and coordination.

Although concussions usually are caused by a blow to the head, they can also occur when the head and upper body are violently shaken. These injuries can cause a loss of consciousness, but most concussions do not. Because of this, some people have concussions and don't realize it.

Concussions are common, particularly if you play a contact sport, such as football. But every concussion injures your brain to some extent. This injury needs time and rest to heal properly. Luckily, most concussive traumatic brain injuries are mild, and people usually recover fully.

Symptoms:
The signs and symptoms of a concussion can be subtle and may not be immediately apparent. Symptoms can last for days, weeks or even longer.

The most common symptoms after a concussive traumatic brain injury are headache, amnesia and confusion. The amnesia, which may or may not be preceded by a loss of consciousness, almost always involves the loss of memory of the impact that caused the concussion.

Signs and symptoms may include:

- Headache or a feeling of pressure in the head
- Temporary loss of consciousness
- Confusion or feeling as if in a fog
- Amnesia surrounding the traumatic event
- Dizziness or "seeing stars"
- Ringing in the ears
- Nausea or vomiting
- Slurred speech
- Fatigue

The well-being of its Student Athletes is of paramount importance to the School. Coaches are trained annually in recognizing the signs and symptoms of concussions and are required immediately to remove from practice, conditioning, or a game any Student Athlete who shows such signs. Student Athletes will not be permitted to return until a Health Care Provider has either ruled out a concussion or determines the Student Athlete capable of returning. In no instance will a Student Athlete with a diagnosed concussion return the same day.

PRINTED Student Name:____________________________________

Signature of Student: ____________________________Date:__________

PRINTED Parent Name:____________________________________

Signature of Parent: ____________________________Date:__________

[1] http://www.mayoclinic.com/health/concussion/DS00320.

WORKSMART
OCCUPATIONAL HEALTH
A service of TIFT REGIONAL MEDICAL CENTER

______________________________ ________________

PRINT ATHLETE's NAME Date of Birth

CONSENT FOR ON-SITE SCREENINGS

In consideration of medical health screenings, which is provided to me by WorkSmart Occupational Health Clinic, a facility of Tift Regional Health System, I do hereby agree and consent as follows:

1. **CONSENT AND EXAMINATION AUTHORIZATION.**
I (or the undersigned representative acting on behalf of the patient) do hereby consent to and authorize the administration of the following examination and screening. This screening may be provided or required by my employer ____________________ or school __________________.

2. **EXAMINATION AND SCREENING IS NOT A COMPLETE MEDICAL EXAMINATION.** I recognize and accept all risks associated with the examination and screening services provided. I understand that the examination and screening is only an examination and screen for abnormalities and does not constitute a complete medical examination or diagnosis. For a diagnosis of a medical problem, I must see a physician for a complete medical examination.

3. **RECORDS OF THE EXAMINATION AND SCREENING.** I recognize and understand that WorkSmart, as a department of Tift Regional Health System, will not maintain any records or findings related to the examination and screening as part of my medical record. The total sports exam required by the Georgia High School Association will be maintained by the Tift County High School Athletic Department as part of participation in sports programs.

4. **UNDERSTANDING OF CONSENT.** I certify by execution of this Consent that I have read and understand the above conditions of examination and screening and that I am legally authorized to execute this Consent to Medical Examination and Screening on behalf of the Patient.

I AM AWARE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO RESULTS OF EXAMINATION OR SCREENS.

______________________________ ________________ ______________

Parent or Guardian signature **Date** **Time**

____

Witness