

# DULUTH HS PHYSICAL, CONSENT & INSURANCE FORM

**ALL PAGES MUST BE COMPLETED PRIOR TO STUDENT PARTICIPATION IN ATHLETICS**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_ Duluth High \_\_\_\_\_ 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 \_\_\_\_\_

| 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: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections<br>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: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> 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  | Yes | No |
| 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  |     |    |
| _____   |     |    |
| _____   |     |    |
| _____   |     |    |
| _____   |     |    |
| _____   |     |    |
| _____   |     |    |
| _____   |     |    |
| _____   |     |    |
| _____   |     |    |

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 \_\_\_\_\_

Student No.

Grade

First Name

Last Name

# PHYSICAL EXAMINATION FORM /CLEARANCE FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
  - Do you feel stressed out or under a lot of pressure?
  - Do you ever feel sad, hopeless, depressed, or anxious?
  - Do you feel safe at your home or residence?
  - Have you ever tried cigarettes, 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 seatbelt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5–14).

| EXAMINATION  |         |                               |  |
|--|---------|-------------------------------|--|
| Height   | Weight  | <input type="checkbox"/> Male | <input type="checkbox"/> Female  |
| BP   | / ( / ) | Pulse                         | Vision R20/ L2D/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> 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 parent. 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) \_\_\_\_\_ Phone \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Signature of Physician \_\_\_\_\_ Date of Exam: \_\_\_\_\_

# EMERGENCY INFORMATION

Allergies \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Other Information \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Preparticipation Physical Evaluation THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

|  |     |    |
|--|-----|----|
| 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:  |     |    |
| _____  |     |    |
| _____  |     |    |
| _____  |     |    |

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:                   |     |    |
| _____   |     |    |
| _____   |     |    |
| _____   |     |    |
| _____   |     |    |

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 \_\_\_\_\_

**PLEASE CONTINUE AND COMPLETE ALL PAGES OF THIS FORM.**

**ALL SECTIONS MUST BE COMPLETED BEFORE A STUDENT IS ALLOWED TO PARTICIPATE IN ANY CONDITIONING, TRY-OUTS OR TEAM COMPETITION.**

**Gwinnett County Public Schools**  
**CONSENT, INSURANCE AND ATHLETIC PHYSICAL FORM - MUST BE COMPLETELY FILLED IN**  
**PARENTAL CONSENT FOR ATHLETIC PARTICIPATION**

**WARNING:** although participation in supervised interscholastic athletics and activities may be one of the least hazardous in which students will engage in or out of school, by its nature, participation in interscholastic athletics includes a risk or injury which may range in severity from minor to long term catastrophic, including permanent paralysis from the neck down or death. Although serious injuries are not common in supervised school athletic programs, it is possible only to minimize, not eliminate the risk.

Participants can and have the responsibility to help reduce the chance of injury. **Players must obey all safety rules, report all physical problems to their coaches, follow a proper conditioning program, and inspect their equipment daily.**

By signing this permission form, you acknowledge that you have read and understand this warning. **Parents or students who do not wish to accept the risks described in this warning should not sign this permission form.**

I (we) hereby give consent for \_\_\_\_\_ residing at \_\_\_\_\_ to:

- (1) Compete in athletics at DULUTH High School of the Gwinnett County School District in Georgia High School Association approved sports.
- (2) To accompany any school team of which the student is a member on any of its local or out-of-town trips;
- (3) I hereby verify that the information on both sides of this form is correct and understand that any false information may result in my son/daughter being declared ineligible.

The student is domiciled at the above address located in the \_\_\_\_\_ High School District.

Have you attended this Gwinnett County school for at least one full school year? Yes \_\_\_ No \_\_\_

**EMERGENCY CONTACTS -- PLEASE PRINT CLEARLY:**

Name of Father/Guardian \_\_\_\_\_ Telephone Work: \_\_\_\_\_ Cell \_\_\_\_\_

Name of Mother/Guardian \_\_\_\_\_ Telephone Work: \_\_\_\_\_ Cell \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone Work: \_\_\_\_\_ Cell \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Telephone Number \_\_\_\_\_

Date of Physical \_\_\_\_\_ Date Entered 9th Grade \_\_\_\_\_ Your Grade Level This Year \_\_\_\_\_

This acknowledgment of risk and consent to allow participation shall remain in effect until revoked in writing.

**INSURANCE INFORMATION - MUST BE COMPLETED**

Please INITIAL one of the following statements regarding insurance coverage for your son/daughter for the \_\_\_\_\_ school year, then sign below.

\_\_\_\_\_ My son/daughter is adequately and currently covered by accident insurance that will cover injuries sustained while participating in interscholastic athletics (including, but not limited to, varsity and junior varsity football).

Company Providing Insurance: \_\_\_\_\_ Group: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Policy#: \_\_\_\_\_

\_\_\_\_\_ I wish to purchase the Benefit Plan provided by the Gwinnett County School System.  
 (A signed copy of this Benefit Plan should be stapled to this form.)

**AUTHORIZATION**

I certify that the medical history on this form is complete and accurate. I understand that this will serve as the basis for determining that my child, \_\_\_\_\_ may compete in high school athletics in Gwinnett County Schools. I also understand that this medical evaluation is only to determine fitness for athletics and is not to take the place of regular medical examinations. In case of an emergency or accident on the school grounds or during any school activity involving my child, \_\_\_\_\_ which in the opinion of school authorities present requires immediate medical or surgical attention, I hereby grant permission to physicians, consulting physicians, athletic trainers, emergency medical technicians, and other healthcare providers selected by school authorities to provide medical care and treatment (including hospitalization if deemed appropriate by school authorities or an appropriate healthcare provider) unless I am present and request otherwise or until I later request otherwise.

**ATHLETIC CODE OF CONDUCT**

Gwinnett County Public Schools' athletic programs are a great source of pride to our communities. Involvement in athletics helps students develop a better sense of responsibility, cooperation; self-discipline, self-confidence, and sportsmanship that will help serve them long after graduation. The lessons and values learned by participating on athletic teams last a lifetime.

All athletes are expected to abide by the highest standards of fair play and sportsmanship while on the court or field. We also have high expectations regarding behavior when the students are not engaged in athletic competitions. Students participating in Georgia High School Association extracurricular athletic activities act as representatives of Gwinnett County Public Schools. All students are expected to conduct themselves in such a manner as to meet the highest standards of the school system at all times.

The Athletic Code of Conduct is designed to establish high expectations and standards for all students participating in Georgia High School sanctioned athletic activities. The Code of Conduct also provides consistent consequences when violations occur. The consequences listed on the Code of Conduct are minimum standards. The schools can set consequences over and above those listed on the Code of Conduct.

I have read the Gwinnett County Athletic Code of Conduct in the Discipline Handbook and I understand the potential consequences that go along with violating the Athletic Code of Conduct.

**PLEASE SIGN HERE:**

This signature consents to athletic participation, medical authorization, verification of insurance coverage, code of conduct, and permission to use the athletes picture and/or video on our school web site, and all other forms of media available to Duluth High School.

Signature of Athlete \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_



**CONSENT FOR COGNITIVE TESTING  
and RELEASE OF INFORMATION**

I give my permission for (name of child) \_\_\_\_\_

(child's date of birth) \_\_\_\_\_

to have a baseline and post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) administered at DULUTH HIGH SCHOOL. I understand that my child may need to be tested more than once, depending upon the results of the test, as compared to my child's baseline test, which is on file at the school. I understand there is no charge for the testing.

DULUTH HIGH SCHOOL'S certified athletic trainer may release the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results to my child's primary care physician, team physician, neurologist, or other treating physician as necessary for proper care.

I understand that general information about the test data may be provided to my child's guidance counselor and teachers, for the purposes of providing temporary academic modifications, if necessary.

Name of parent or guardian: \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_

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

**PLEASE PROVIDE THE FOLLOWING INFORMATION:**

Name of doctor: \_\_\_\_\_

Name of practice or group: \_\_\_\_\_

Phone number: \_\_\_\_\_

Student's home address: \_\_\_\_\_

Parent or guardian phone numbers (please indicate preferred contact number & time if necessary):

\_\_\_\_\_ (H) \_\_\_\_\_ (W)

\_\_\_\_\_ (cell)

*Gwinnett Medical Center*

1000 Medical Center Boulevard | Lawrenceville, GA 30045 | 678-312-4321 | [gwinnetmedicalcenter.org](http://gwinnetmedicalcenter.org)



## Medication Authorization

Name: \_\_\_\_\_

Date: \_\_\_\_\_ Sport(s): \_\_\_\_\_ DOB: \_\_\_\_\_

This letter is for the authorization of medications to be given to DULUTH Student Athletes. Please check if the athlete is able to take these medications. If athlete cannot have these medications, please write an explanation at the bottom of the page.

\_\_\_ Advil (ibuprofen)

\_\_\_ Tylenol (acetaminophen)

\_\_\_ Aleve (naproxen sodium)

\_\_\_ Pepto-Bismol/TUMS (bismuth subsalicylate)

\_\_\_ Heal Guard (electrolytes)

\_\_\_ Benadryl (diphenhydramine HCL) – for allergic reactions

List any other medications that you may wish to be provided:

\_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:**

\_\_\_\_\_

*These authorizations are effective until such time that the signer submits a written and dated revocation of this document.*

Gwinnett Medical Center

1000 Medical Center Boulevard | Lawrenceville, GA 30045 | 678-312-4321 | [gwinnettmedicalcenter.org](http://gwinnettmedicalcenter.org)



### Consent to Treatment and Release of Medical Information

Name: \_\_\_\_\_

Date: \_\_\_\_\_ Sport(s): \_\_\_\_\_ DOB: \_\_\_\_\_

I give authorization to the Gwinnett Hospital System (GHS) athletic training staff and student athletic trainers working with the GHS athletic training staff, to evaluate and treat any injuries or illnesses that may occur during his/her athletic participation at DULUTH HIGH SCHOOL.

This includes immediate first aid to my child, treatment, physical exam, and diagnostic procedures. No guarantees have been made that the evaluation, treatment, or rehabilitation services that my child receives will cure or fully return him/her to athletic participation.

I authorize necessary medical treatment and admission to any medical facility designated by the GHS athletic training staff or team physician.

I understand that I have the right to make decisions concerning my child's health care, including the right to refuse medical treatment and surgical procedures. However, I also understand that the final decision as to whether my child may participate in athletic activities at DULUTH HIGH SCHOOL rests solely with the GHS athletic training staff and team physician.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

#### To Athletic Trainers, Physicians, Hospitals, Clinics, and all Other Agencies:

If needed, You are hereby authorized and requested to give the GHS athletic training department a complete copy of all your records pertaining to my child's medical treatment including, but is not limited to, all physicals, athletic trainer's records, and any diagnosis, treatment, history and prognosis of any and all injuries.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

*These authorizations are effective until such time that the signer submits a written and dated revocation of this document.*

Gwinnett Medical Center

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## Alternative Transportation Liability Form

Gwinnett County Public Schools/ \_\_\_\_\_ (name of school) is not always able to provide transportation for students to off campus extracurricular school activities. In cases when transportation is not provided by Gwinnett County Public Schools/ \_\_\_\_\_ (name of school) as in the use of a school bus or charter bus, it is the responsibility of the student's parents or guardian to secure their student's attendance at such activities. Gwinnett County Public Schools, its local schools, officers, employees or agents shall not be responsible for any injury or loss arising out of a student's transportation to or from the off campus activity when such transportation is provided by parents, students, school staff or any other party. Your signature acknowledges your receipt of and understanding of this policy.

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Activity

\_\_\_\_\_  
Date of Activity

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date



# 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.
- c) It is mandatory that every coach in each GHSA sport participate in a free, online course on concussion management prepared by the NFHS and available at [www.nfhslearn.com](http://www.nfhslearn.com) at least every two years – beginning with the 2013-2014 school year.
- d) Each school will be responsible for monitoring the participation of its coaches in the concussion management course, and shall keep a record of those who participate.

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

SIGNED: \_\_\_\_\_  
(Student)

\_\_\_\_\_  
(Parent or Guardian)

DATE: \_\_\_\_\_